MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10334

# CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
STREET ADDRESS (If rural, give location) 4540 Fairfield Drive

3. NAME OF DECEASED (Type or Print) (First) Martha (Middle) Elizabeth (Last) Abbuhl

4. DATE OF DEATH (Month) Oct. (Day) 26 (Year) 1950

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow
8. DATE OF BIRTH Jan. 15, 1874
9. AGE last birthday 76 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Germany
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME William Noethlig
14. MOTHER'S MAIDEN NAME Hulda Tomay

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT AND ADDRESS Mrs. Louise Farley (daughter)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X Immediate cause (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 15 hours

Antecedent cause(s)

83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/25, 1950, to 10/26, 1950, that I last saw the deceased alive on 10/25, 1950, and that death occurred at 3:20 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Bruce T. Benjamin MD. ADDRESS 4700 Glenbrook Parkway Bethesda DATE SIGNED Md.

23. BURIAL, CREMATION REMOVAL (Specify) Burial-Transit
DATE 26 Oct. 1950
NAME OF CEMETERY OR CREMATORY Rome Cemetery
LOCATION (City, town, or county) (State) Rome, New York

DATE REC'D BY LOCAL REG. 10-26-50
REGISTRAR'S SIGNATURE Helen Kurvack.
24. FUNERAL DIRECTOR Robert H. Pumphrey ADDRESS Bethesda, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 30 1950
BUREAU OF S

MARYLAND STATE DEPARTMENT OF HEALTH

10335

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 214

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 8200 New Hampshire Ave., Apt. 303

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
STREET ADDRESS (If rural give location) 8200 New Hampshire Ave. Apt. 303

3. NAME OF DECEASED (Type or Print): (First) Elizabeth (Middle) M. (Last) Allen

4. DATE OF DEATH: (Month) Oct. (Day) 7 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Dec. 18, 1949

9. AGE last birthday: yrs. — If under 1 year: Months 9 — Days 19 — If under 24 hrs.: Hours — Mln.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): New Jersey

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ollie James Allen

14. MOTHER'S MAIDEN NAME: Beatrice Moulton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mr. Ollie James Allen, 8200 N. Hampshire Ave.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

754.4 Immediate cause (a) Congenital heart disease — Interval between onset and death: died suddenly

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
157.2 (b)
(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy* ☒, *Inspection* ☐, *Inquiry* ☐ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Frank J. Brockhurst M.D. Gaithersburg Md 10-7-50

23. BURIAL, CREMATION REMOVAL (Specify): Cremation
DATE THEREOF: Oct. 9, 1950
NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Crematory
LOCATION (City, town, or county) (State): Prince Geo. County Md.

DATE REC'D BY LOCAL REG. 10/9/50
REGISTRAR'S SIGNATURE Frances Potter

24. FUNERAL DIRECTOR: Warner E. Pumphrey, ADDRESS: 8434 Ga. Ave., Silver Spring Maryland

9-V-V-18-9-99V99V

VS. A15A

RECEIVED
OCT 11 1950
BUREAU V. S

10336

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 214

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY Montgomery MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring — LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS 9504 Old Bladensburg Road | STREET ADDRESS (If rural, give location) 9504 Old Bladensburg Road |

| | | | | | |
|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) | (First) Anna | (Middle) Maloney | (Last) Anderson | 4. DATE OF DEATH | (Month) Oct. (Day) 9 (Year) 1950 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH July 1, 1875 | 9. AGE last birthday 75 yrs. | If under 1 year Months / Days; If under 24 hrs. Hours / Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Kenosha, Wisconsin | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME John Maloney | 14. MOTHER'S MAIDEN NAME Helen Hale | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | 16. SOCIAL SECURITY No. None | 17. INFORMANT AND ADDRESS Mrs. Henry Burroughs, 9504 Old Bladensburg Rd. | | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Right hemiplegia (Cerebral Hemorrhage) | 4 days. |
| 442X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Cardio-vascular-renal disease | Sev. yrs. |
| 131a | (c) with Hypertension. | |

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. — —

| | | |
|---|---|---|
| 19a. DATE OF OPERATION — | 19b. MAJOR FINDINGS OF OPERATION — | 20. AUTOPSY? Yes ☐ No ☒ |

| | | | |
|---|---|---|---|
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) — | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — | (CITY OR TOWN) — (COUNTY) (STATE) | |
| TIME OF INJURY (Month) (Day) (Year) (Hour) — m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? — | |

22. I hereby certify that I attended the deceased from Jan., 1950 to Oct 9, 1950, that I last saw the deceased alive on Oct 8, 1950 and that death occurred at 6:30A m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Lynwood Heiges M.D. | | 6940 Piney Branch Rd. NW. | 10/9/50. |

| | | | | |
|---|---|---|---|---|
| 23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE THEREOF Oct. 11, 1950 | NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery | LOCATION (City, town, or county) Baltimore | (State) Md. |
| DATE REC'D BY LOCAL REG. 10/10/50 | REGISTRAR'S SIGNATURE Frances Potter | 24. FUNERAL DIRECTOR Warner E. Phosphrey | ADDRESS 8434 Ga. Ave., Silver Spring Maryland | |

52086

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 11 1950
BUREAU T. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10337

# CERTIFICATE OF DEATH

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Monte
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
STREET ADDRESS (If rural, give location) 4915 Auburn Avenue

3. NAME OF DECEASED (Type or Print): (First) Baby (Middle) Boy (Last) Anderson

4. DATE OF DEATH: (Month) Oct. (Day) 22 (Year) 1950

5. SEX: male — 6. COLOR OR RACE: white — 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Newborn — 8. DATE OF BIRTH: Oct. 22/50 — 9. AGE last birthday: ____ yrs. — If under 1 year: Months ____ Days ____ — If under 24 hrs.: Hours ____ Min. 6hr.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ____
10b. KIND OF BUSINESS OR INDUSTRY: ____
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Strother Robert Anderson
14. MOTHER'S MAIDEN NAME: Sarah Isabell McCracken

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): ____
16. SOCIAL SECURITY NO.: ____
17. INFORMANT AND ADDRESS: Suburban Hospital

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

**Immediate cause** (a) Prematurity (5 mo.)

7767 **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
159 (b) ____
(c) ____

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: ____ — 19b. MAJOR FINDINGS OF OPERATION: ____ — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ____, 1950, to ____, 1950, that I last saw the deceased alive on 4/30, 1950, and that death occurred at 5:15 P m., from the causes and on the date stated above.

SIGNATURE: [signature] (Degree or title) — ADDRESS 8016 [illegible] — DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) — DATE THEREOF 10/25/50 — NAME OF CEMETERY OR CREMATORY Wash. National Cemetery — LOCATION (City, town, or county) Suitland, Md. (State)

DATE REC'D BY LOCAL REG. Oct 23/50 — REGISTRAR'S SIGNATURE Helen Kurvack — 24. FUNERAL DIRECTOR H. H. Chambers — ADDRESS 3012 M. St., N. W.

2-0-0-22-0-38-3-20-0

RECEIVED
OCT 27 1950
BUREAU

10338

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH — COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: BETHESDA
LENGTH OF STAY (in this place): 1 da. 10 hrs 10 min
HOSPITAL OR INSTITUTION OR STREET ADDRESS: SUBURBAN HOSPITAL 8600 OLD GEORGETOWN ROAD

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda
STREET ADDRESS (If rural, give location): 4400 Montgomery Ave.

3. NAME OF DECEASED (Type or Print): (First) Sera (Middle) L (Last) Apple
4. DATE OF DEATH: (Month) 10 (Day) 11 (Year) 1950
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Aug. 19, 1896
9. AGE last birthday: 54 yrs. If under 1 year: Months 1, Days 22; If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Saginaw Michigan
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: George F. Metcalf
14. MOTHER'S MAIDEN NAME: Ruth Ellen Law
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT AND ADDRESS: Paul C. Apple

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Hemorrhage — 2 1/2 days

443X Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive Cardio Vascular Disease — 14 yr.

(c)

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death. Cerebral Hemorrhage - Left c Hemiplegia — 5 mo.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify): PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.: INJURY OCCURRED While at Work ☐ Not While At work ☐: HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1940, to 10 oct, 1950, that I last saw the deceased alive on 10 oct, 1950, and that death occurred at 4:55 A.m., from the causes and on the date stated above.

SIGNATURE: John G. Ball (Degree or title) M.D. ADDRESS: 7936 Georgetown Rd Bethesda Md. DATE SIGNED: Oct 11, 1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 14 Oct. 1950 — NAME OF CEMETERY OR CREMATORY: Ft. Lincoln — LOCATION (City, town, or county) (State): Prince George, Maryland

DATE REC'D BY LOCAL REG.: 10-12-50 — REGISTRAR'S SIGNATURE: Helen Kurvacky — 24. FUNERAL DIRECTOR: Robert A. Humphrey — ADDRESS: Bethesda, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 18 1950

1

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10339

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH: COUNTY Montgomery Co. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park. LENGTH OF STAY (in this place) 4 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS 120 Albany Ave

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE District of Columbia COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural, give location) 3020 Tilden St. N.W. D.C.

3. NAME OF DECEASED (Type or Print): (First) KATHERINE (Middle) AMELIA (Last) BABB
4. DATE OF DEATH: (Month) Oct. (Day) 5 (Year) 19 50

5. SEX: Female
6. COLOR OR RACE: White.
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married
8. DATE OF BIRTH: 9/19/79
9. AGE last birthday: 70 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Maysville, W. Va.
12. CITIZEN OF WHAT COUNTRY? American

13. FATHER'S NAME: Arnold C. Scherr
14. MOTHER'S MAIDEN NAME: Katharine NICHOLS.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT AND ADDRESS: Husband, 3020 Tilden St. N.W. D.C.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

331 IX — Immediate cause (a) bronchopneumonia, terminal

Antecedent cause(s)

83a — Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) cerebral hemorrhage — 3 months

(c) generalized arteriosclerosis.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 6, 19 50, to October 5, 19 50, that I last saw the deceased alive on October 4, 19 50, and that death occurred at 10:10 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED
Frederic Brennwald M.D. — Takoma Park — Oct. 5, 1950

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — DATE: Oct 9 1950 — NAME OF CEMETERY OR CREMATORY: Arlington Nat. Cem. — LOCATION (City, town, or county) (State): Arlington Co. Va.

DATE REC'D BY LOCAL REG. 10/5/50. — REGISTRAR'S SIGNATURE: J. Wilson Dodd
24. FUNERAL DIRECTOR — ADDRESS: Beach Funeral Home 3034 M St. N.W. Wash DC

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 9 1950
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10340

# CERTIFICATE OF DEATH

Reg. Dist. No. 214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springbrook

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Mont.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Spring Brook Silver Spring
STREET ADDRESS (If rural, give location) Spring Brook

3. NAME OF DECEASED (Type or Print): (First) Rosary (Middle) Frances (Last) Bailey

4. DATE OF DEATH: (Month) Oct (Day) 2 (Year) 1950

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Oct 4, 1874

9. AGE last birthday: 75 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Washington D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Anthony De Vote

14. MOTHER'S MAIDEN NAME: Maria Tugley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Harry D. Bailey - Same.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|---|
| 450.0 | Immediate cause | (a) Cardiac Decompensation | about 2-3 yrs |
| 950 | Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Arteriosclerosis | ? |
| | | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March, 1950, to Oct, 1950, that I last saw the deceased alive on 30 Sept, 1950, and that death occurred at 2:30 a.m., from the causes and on the date stated above.

SIGNATURE: William D. Arnold (Degree or title) M.D. ADDRESS: Silver Spring, Md. DATE SIGNED: 2 Oct 50

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: Oct 4, 1950 | NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery | LOCATION (City, town, or county) (State): Suitland, Md.

DATE REC'D BY LOCAL REG.: 10/5/50 | REGISTRAR'S SIGNATURE: Frances Potter | 24. FUNERAL DIRECTOR: Timothy Hanlon | ADDRESS: 641 H St. NE.

RECEIVED
OCT 5 1960
BUREAU V. S.

Copy

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10341

# CERTIFICATE OF DEATH

Reg. Dist. No. 223.

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH — COUNTY: Montgomery. — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Takoma Park — LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Washington Sanitarium & Hospital Takoma Park. Md

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland. — COUNTY: Pr. Geo. Frederick
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt. Rainier
STREET ADDRESS (If rural, give location): 4307 Eastern Ave.

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| William | Edward. | Basford | 10 | 24 | 1950 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Widower | 2-22-67 | 83 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Carpenter - B.T.O.R.R. | Railroad | Dowbs Maryland | U.S.A |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Jacob Basford | Henrietta Penn |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| | | Hospital Records |

18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| 15 X Immediate cause | (a) Exanition | Terminal |
| Antecedent cause(s) | | |
| 46 g Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Carcinoma of Pancreas | 2 yrs |
| | (c) | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | |

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☒ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from 9/29, 1950, to 10/24, 1950, that I last saw the deceased alive on 10/23, 1950, and that death occurred at 5:30 a.m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Delos K Meade by Robert A Hare M.D. | associate | Takoma Park Md. | 10/24/50 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| | 10/24/50 | | Frederick | Md |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 10/24/50 | J Wm Dodd | M R Etchison & Son | 106 E Church St Frederick Md |

30847

RECEIVED
OCT 25 1950
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10342

# CERTIFICATE OF DEATH

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda, Rural; LENGTH OF STAY (in this place) 5 mo 12 da; HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: COUNTY; STATE District of Columbia; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington; STREET ADDRESS (If rural, give location) 5461 32nd Street, N.W.

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) Emma (Last) BECKER

4. DATE OF DEATH: (Month) (Day) (Year) October 10, 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: May 20, 1894

9. AGE last birthday: 56 yrs. If under 1 year: Months 04 Days 21 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: - - - - - -

11. BIRTHPLACE (State or foreign country): New Hampshire

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Clarence MATHEWS

14. MOTHER'S MAIDEN NAME: Annie MARDEN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) - - - - -

16. SOCIAL SECURITY NO. - - - - - - -

17. INFORMANT AND ADDRESS: Husband: William F. BECKER

18. MEDICAL CERTIFICATION: Same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Metastatic Disease | 1 yr. |
| 170X 50 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Carcinoma Breast | 4-5 yr. |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr. 29, 1950, to Oct 10, 1950, that I last saw the deceased alive on Oct 10, 1950, and that death occurred at 7:40 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

E. M. SPAULDING, CDR, MC, USN U.S. NAVAL HOSPITAL October 10, 1950

23. BURIAL, CREMATION, REMOVAL (Specify) Removal | DATE THEREOF Oct. 11, 1950 | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) Portsmouth, New Hamp.

DATE REC'D BY LOCAL REG. Oct. 11, 1950 | REGISTRAR'S SIGNATURE Edith Worthington

24. FUNERAL DIRECTOR ADDRESS: R. A. Pumphrey Funeral Home, 7557 Wisconsin Avenue, Bethesda, Md.

RECEIVED
OCT 13 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10343

# CERTIFICATE OF DEATH

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda, Rural
LENGTH OF STAY (in this place) 3 mo 21 da
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE District of Columbia; COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural, give location) 402 R Street, N.W.

3. NAME OF DECEASED (Type or Print): (First) William (Middle) (none) (Last) BELL

4. DATE OF DEATH: (Month) October (Day) 9, (Year) 1950

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Dec. 5, 1905

9. AGE last birthday: 44 yrs. If under 1 year: Months 10 Days 05 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bus Boy

10b. KIND OF BUSINESS OR INDUSTRY: Hotel

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Walter BELL

14. MOTHER'S MAIDEN NAME: Rhoda EDMONDS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war, or dates of service) WW II

16. SOCIAL SECURITY NO. - - - - - - - - -

17. INFORMANT AND ADDRESS: Sister: Matilda TUCKER, 1718 M St., N.W., Washington, D.C.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

441X

Immediate cause (a) Hypertensive Cardiovascular Disease, Malignant — Interval between onset and death: 3 years

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

93d

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 19, 1950, to Oct 9, 1950, that I last saw the deceased alive on Oct. 9, 1950, and that death occurred at 11:15 P m., from the causes and on the date stated above.

SIGNATURE R. O. Peckinpaugh (Degree or title) R. O. PECKINPAUGH, LTJG, MC, USN ADDRESS U.S. NAVAL HOSPITAL DATE SIGNED October 10,1950

23. BURIAL, CREMATION REMOVAL (Specify): Removal

DATE THEREOF: Oct 10,1950

NAME OF CEMETERY OR CREMATORY: Mt. Pleasant Cemetery

LOCATION (City, town, or county) (State): Alberta, Virginia

DATE REC'D BY LOCAL REG.: Oct. 10,1950

REGISTRAR'S SIGNATURE: Elsie Whittington

24. FUNERAL DIRECTOR ADDRESS: W. E. Jarvis, 1432 U Street, NW, Washington, D.C.

77087 W. Ernest Jarvis Co. Inc.

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OCT 13 1950
BUREAU V. S

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10344

# CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Olney
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS The Montgomery County General Hospital Inc.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gaithersburg
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Martin (Middle) (Last) Best

4. DATE OF DEATH (Month) October (Day) 12 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Nov. 7 1874
9. AGE last birthday 76 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Farm
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Simon Best
14. MOTHER'S MAIDEN NAME Martha Hildabrant

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no
16. SOCIAL SECURITY No. ---
17. INFORMANT AND ADDRESS Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Metastasis — Interval Between Onset and Death: 1 year

177X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Carcinoma of Prostate — 3 years

51b (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION 4/1/50
19b. MAJOR FINDINGS OF OPERATION Malignant Prostatic Hypertrophy
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/1/, 1949, to 10/12/, 1950, that I last saw the deceased alive on 10/11/, 1950, and that death occurred at 5 a m., from the causes and on the date stated above.

SIGNATURE (Degree or title) J M Bird M.D. ADDRESS Sandy Spring DATE SIGNED 10/12/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Oct 14. 1950
NAME OF CEMETERY OR CREMATORY St John Olney
LOCATION (City, town, or county) Montgomery (State) Md

DATE REC'D BY LOCAL REG. 10-13-50
REGISTRAR'S SIGNATURE Gertrude B Fowler
24. FUNERAL DIRECTOR Roger W Barber
ADDRESS Laytonsville Md

RECEIVED
OCT 23 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

10345

Reg. Dist. No. 216

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY Montgomery MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda — LENGTH OF STAY (in this place) 3 yrs. | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Own Home | STREET ADDRESS (If rural give location) 4604 Glennbrook Pkwy. |

| | | | | | | |
|---|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) (First) SAMUEL (Middle) I. (Last) BOND | | | | 4. DATE OF DEATH (Month) Oct. (Day) 6, (Year) 1950 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married | 8. DATE OF BIRTH 4 Aug. 1910 | 9. AGE last birthday 40 yrs. | If under 1 year Months 1 Days 26 | If under 24 hrs. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gas Station Operator | 10b. KIND OF BUSINESS OR INDUSTRY Gasoline Business | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Wiley Bond | | | 14. MOTHER'S MAIDEN NAME Flora Thompson | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. 579-16-7507 | | 17. INFORMANT Jane K. Bond 4604 Glennbrook Pkwy. Bethesda, Md. | | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| 420.1 Immediate cause | (a) Coronary occlusion | Found dead in bed |
| 94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) | |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒ |
| 21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE) |
| TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR? |

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Frank J. Brosshart | M.D. | Gaithersburg Md | 10-6-50 |

| | | | |
|---|---|---|---|
| 23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE THEREOF 9 Oct. 1950 | NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | LOCATION (City, town, or county) (State) Suitland, Maryland |
| DATE REC'D BY LOCAL REG. 10-8-50 | REGISTRAR'S SIGNATURE Helen Kurvach | 24. FUNERAL DIRECTOR Robert A. Humphrey | ADDRESS Bethesda, Md. |

41671

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
OCT 16 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

10346

Reg. Dist. No. 218

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington Grove
LENGTH OF STAY (In this place) 3 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Grove Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Monty
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington Grove
STREET ADDRESS (If rural give location) Grove Ave

3. NAME OF DECEASED (Type or Print) (First) William (Middle) Albert (Last) Booth

4. DATE OF DEATH (Month) Oct (Day) 27 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH 12-25-1889
9. AGE last birthday 60 yrs. If under 1 year Months 10 Days 2 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist engineer
10b. KIND OF BUSINESS OR INDUSTRY National of Health
11. BIRTHPLACE (State or foreign country) N.Y.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Frederick Booth
14. MOTHER'S MAIDEN NAME Louise Prince

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 149-07-5634
17. INFORMANT Carol Gomez

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Coronary occlusion | 20 min. |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) | |
| | (c) | |

420.1
94a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE Frank J. Broschart (Degree or title) M.D. ADDRESS Gaithersburg, Md DATE SIGNED 10-27-50

23. BURIAL, CREMATION REMOVAL (Specify) Cremation
DATE THEREOF 10/30/50
NAME OF CEMETERY OR CREMATORY Frost Funeral Ln.
LOCATION (City, town, or county) (State) Bladensburg-Md.

DATE REC'D BY LOCAL REG. Oct. 28, 1950
REGISTRAR'S SIGNATURE Alberta G. Cooke
24. FUNERAL DIRECTOR E. C. Gartner ADDRESS Gaithersburg Md.

11697

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
OCT 31 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

10347

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

213

Reg. Dist. No. [redacted]

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Boyd, Md; LENGTH OF STAY (In this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland Montgomery; COUNTY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Boyd, Md; STREET ADDRESS (If rural give location)

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Leroy | | Bowie | Oct | 1 | 1950 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Colored | single | Jan 5, 1927 | 23 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | B&O R.R. | Montgo. Co. Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Unknown | Unknown |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|
| No | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

825.5 / 170C

**Immediate cause** (a) Cerebral hemorrhage due to

**Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) fracture of skull

(c)

INTERVAL BETWEEN ONSET AND DEATH: sudden death

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. fracture of upper jaw rt.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒ |
|---|---|---|
| | | |

| 21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY highway | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | Hunting Hill | Monty | Md |

| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at work ☐ Not while at work ☒ | HOW DID INJURY OCCUR? |
|---|---|---|
| Oct 1 50 11 a.m. | | auto accident |

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

| SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|
| Frank J. Burchart M.D. | Gaithersburg Md | 10-1-50 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/4/50 | Rocky Hill | Clarksburg, Md |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 10/4/50 | Peggy H. Veazey | Robert L. Snowden | |

VS. A15A

98847

RECEIVED
OCT 5 1950
BUREAU V. S

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

10348

Reg. Dist. No. 216

**1. PLACE OF DEATH:**

County: Mont

City or town: Glen Echo
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs.

Hospital, institution, or street address where death occurred: 6408 McArthur Blvd.

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County:

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 6-408 - MacArthur Blvd
(If rural, give LOCATION)

2.(a) If veteran, name war:

**3. (a) FULL NAME:** Benjamin Branch

**3. (b) Social Security Number:**

4. Sex: M

5. Color or race: col

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Cora Branch

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): about 1800

**8. AGE:** Years: 70 | Months: | Days: | If less than one day ..... hrs. ..... min.

9. Birthplace: Culpepper Va.
(Town, county, and state)

10. Usual occupation: U.S. Government

11. Industry or business: Ret.

FATHER
12. Name:
13. Birthplace: Unk.

MOTHER
14. Maiden name:
15. Birthplace: Unk.

16. Informant: Sherman Branch

Address: 6831-MacArthur Blvd.

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Oct 14, 1950 (month) (day) (year)

Cemetery or crematory: Union Cemetery

Location:

18. Funeral director: Francis Funeral Home, Inc.

Address: 389 R. Ave. N.W.

19. 10-10-50 (Date rec'd by registrar) 19 Helen Kurvaep Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 10 1950, at 9:20 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 13 1950, to Oct 10 1950 and that I last saw him alive on July 9th 1950

| Immediate cause of death | DURATION |
|---|---|
| Uremia | 2 days |
| Due to Hypertension | 4 mos |
| Due to 444 X | |
| Other conditions 132 (Include pregnancy within 3 months of death) | |

Major findings of operations: — Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John Dodson MD
M. D. or other

Address: 2709-P St NW Date signed 10/10/50

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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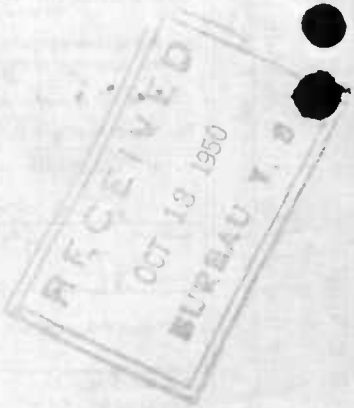
RECEIVED
OCT 13 1950
BUREAU Y. S.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10349

# CERTIFICATE OF DEATH

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
LENGTH OF STAY (In this place) 10 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 4617 Highland Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
STREET ADDRESS (If rural, give location) 4617 Highland Ave.

3. NAME OF DECEASED (Type or Print): (First) Emeline (Middle) (Last) Brown

4. DATE OF DEATH: (Month) Oct. (Day) 16, (Year) 1950

5. SEX: F

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: June 7, 1879

9. AGE last birthday: 71 yrs. If under 1 year: Months 4 Days 19 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Housewife

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Thomas Gordon

14. MOTHER'S MAIDEN NAME: Polly Gillnett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Bryand Culp (son-in-law)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| 194X Immediate cause | (a) Metastasis Bone Cancer | 7 Months |
| Antecedent cause(s) | | |
| 55C Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Probable Thyroid Primary Cancer | 8 " |
| | (c) Unknown | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION: None

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 17, 1944, to Oct 16, 1950, that I last saw the deceased alive on Oct 16, 1950, and that death occurred at 7:30 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Bradley D Hodgkins M.D. ADDRESS 313 W. Bradley Lane DATE SIGNED 10/16/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial-Transit | DATE 17Oct.1950 | NAME OF CEMETERY OR CREMATORY West Side Cemetery | LOCATION (City, town, or county) (State) Sunbury, Pennsylvania

DATE REC'D BY LOCAL REG. 10-16-50 | REGISTRAR'S SIGNATURE Ellen Kunrach | 24. FUNERAL DIRECTOR ADDRESS Robert H Humphrey Bethesda, Md.

VS. A15

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OCT 17 1950
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10350

# CERTIFICATE OF DEATH

Reg. Dist. No. 223

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Prince Georges. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emerg. Room. Walter Reed Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Prince Georges
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park
STREET ADDRESS (If rural, give location) 905 Carroll Ave.

3. NAME OF DECEASED (Type or Print): (First) Anna (Middle) Judith (Last) Burns.

4. DATE OF DEATH: (Month) Oct (Day) 8 (Year) 1950

5. SEX: Fem.

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: Dec 27 1883

9. AGE last birthday: 67 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Penn

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John Henry Schaal

14. MOTHER'S MAIDEN NAME: Barbara Lightner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Mrs. D. Leland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X Immediate cause (a) Cerebral Hemmorrhage — Interval Between Onset and Death: 10/8/50

Antecedent cause(s)

83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 10, 1935, to Oct 8, 1950, that I last saw the deceased alive on 10/8/50, 1950, and that death occurred at 9:15 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Howard Bruce M.D. 28 Carroll Ave Takoma Park Md 10/8/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE: Oct 11, 1950

NAME OF CEMETERY OR CREMATORY: George Washington Cem.

LOCATION (City, town, or county) (State): Riggs Rd. Hyattsville, Pr. Geo. Md.

DATE REC'D BY LOCAL REG.: Oct 8-1950

REGISTRAR'S SIGNATURE: J. Milton Dodd

24. FUNERAL DIRECTOR: J. Arthur Walters

ADDRESS: 234 Carroll St. N.W. Takoma Park D.C.

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OCT 11 1950
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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | |
|---|---|
| 1. PLACE OF DEATH · COUNTY Montgomery MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Maryland COUNTY Montgomery |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BETHESDA — LENGTH OF STAY (in this place) 11 hrs. 42 min. | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda "Kenwood" |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS SUBURBAN HOSPITAL 8600 OLD GEORGETOWN ROAD | STREET ADDRESS (If rural, give location) 205 Highland Drive |

| | | | | | |
|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) | (First) Champ | (Middle) | (Last) Burroughs | 4. DATE OF DEATH | (Month) Oct (Day) 10 (Year) 1950 |
| 5. SEX M | 6. COLOR OR RACE Col | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH April 15 1881 | 9. AGE last birthday 69 yrs. | If under 1 year Months 5 Days 25 — If under 24 hrs. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY Domestic | 11. BIRTHPLACE (State or foreign country) Orange Va | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME Albert Burroughs | | 14. MOTHER'S MAIDEN NAME Lucy Henderson | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | 16. SOCIAL SECURITY No. | 17. INFORMANT AND ADDRESS Elizabeth Little (daughter) 918 P St NW | | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|---|
| Immediate cause | (a) | Post-operative shock | 20 Min. |
| 154X Antecedent cause(s) | (b) | Intestinal obstruction | 24 Hours |
| 46d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (c) | Carcinoma of Rectum with Metastasis | Est. 6 Mo. |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| | | |
|---|---|---|
| 19a. DATE OF OPERATION Oct. 9, 1950 | 19b. MAJOR FINDINGS OF OPERATION Carcinoma of Rectum: Metas. + large bowel obstruction | 20. AUTOPSY? Yes ☐ No ☑ |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) NO | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) none (COUNTY) (STATE) | |
| TIME OF INJURY (Month) (Day) (Year) (Hour) None m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? none |

22. I hereby certify that I attended the deceased from Oct. 9, 1950, to Oct. 10, 1950, that I last saw the deceased alive on Oct. 10, 1950, and that death occurred at 1:42 A.m., from the causes and on the date stated above.

SIGNATURE Herbert M. Giffin (Degree or title) M.D. ADDRESS 1801 K. St. N.W. Washington, D.C. DATE SIGNED

| | | | |
|---|---|---|---|
| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE 10-14-50 | NAME OF CEMETERY OR CREMATORY Lincoln Mem. | LOCATION (City, town, or county) Prince Geo Co. (State) Md. |
| DATE REC'D BY LOCAL REG. Oct. 10/50 | REGISTRAR'S SIGNATURE Helen Kurvack | 24. FUNERAL DIRECTOR M. Kuhn Funeral Service Inc | ADDRESS |

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 13 1950
BUREAU V. R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10352

# CERTIFICATE OF DEATH

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda; LENGTH OF STAY (in this place) 3 da 8 hrs 30 m
HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
STREET ADDRESS (If rural, give location) Carroll Ave. & Piney Branch Rd.

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| David | Henry | Byrd | 10 | 20 | 1950 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | Oct 8 1899 | 51 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Farmer | Rock Creek Cemetery Wash. D.C. | Alabama W. Virginia | U.S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Albert Byrd | Mary Bern |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| | 577-05-0900 | Mrs. Eleanor P. Byrd, Carroll Ave. & Piney Branch Rd., Silver Spring, Md. |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Gangrene jejunum with perforation | 5 days. |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Gastro-jejunostomy with herniation and infarction proximal loop. | |
| | (c) Generalized Peritonitis. | |

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II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Renal Failure with uremia.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 10-16-50 | Perforation jejunum. | Yes ☒ No ☐ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from 10-16, 1950, to 10-20, 1950; that I last saw the deceased alive on 10-20, 1950, and that death occurred at 12:50 A.m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Alan A. Dunn | M.D. Chief Resident | Suburban Hosp. Bethesda, Md. | 10-20-50 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | 10/23/50 | Rock Creek Cemetery | Washington | D.C. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 11-1-50 | Helen Kurreck | Warner & Pumphrey | 8434 Ga. Ave. Silver Spring, Maryland |

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BUREAU V. S

10353

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
STREET ADDRESS (If rural, give location) 8304 - 16th St., Apt. 107

3. NAME OF DECEASED (Type or Print) (First) Sara (Middle) H (Last) Cadmus
4. DATE OF DEATH (Month) Oct. (Day) 8 (Year) 1950

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH Oct. 11, 1870
9. AGE last birthday 79 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) New York
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME George H. Hichcock
14. MOTHER'S MAIDEN NAME Mary Field

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY No. none
17. INFORMANT AND ADDRESS Mr. Geo. H. Galloway

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|---|
| 331x | Immediate cause | (a) Cerebral Hemorrhage | 2 days |
| 83a | Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Hypertension, | 5-10 yrs ? |
| | | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 1948, to 8 Oct, 1950, that I last saw the deceased alive on 8 Oct, 1950 and that death occurred at 11:15 A.m., from the causes and on the date stated above.

SIGNATURE William D. Cand MD (Degree or title) ADDRESS Silver Spring Md DATE SIGNED 8 Oct 50

23. BURIAL, CREMATION REMOVAL (Specify) Burial & Removal
DATE THEREOF 10/9/50
NAME OF CEMETERY OR CREMATORY Moravain Cemetery
LOCATION (City, town, or county) (State) Staten Island, N.Y.
DATE REC'D BY LOCAL REG. 10-8-50
REGISTRAR'S SIGNATURE Helen Kurvach
24. FUNERAL DIRECTOR Wm. J. Tickner & Sons ADDRESS Balto Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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RECEIVED
OCT 10 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10354

# CERTIFICATE OF DEATH

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) Rural — Rockville; MARYLAND LENGTH OF STAY (in this place) 10 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS Waverley Sanitarium

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Dist. of Columbia; COUNTY —; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington D.C.; STREET ADDRESS (If rural, give location) 1709 - P St. N.W. —

3. NAME OF DECEASED (Type or Print): (First) George (Middle) Henry (Last) Calvert

4. DATE OF DEATH: (Month) October (Day) 20 (Year) 1950

5. SEX male; 6. COLOR OR RACE White; 7. ~~SINGLE, MARRIED, WIDOWED, DIVORCED~~ (Specify) married; 8. DATE OF BIRTH Oct 2 1874; 9. AGE last birthday 76 yrs. If under 1 year: Months —, Days —; If under 24 hrs.: Hours —, Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer; 10b. KIND OF BUSINESS OR INDUSTRY Lawyer; 11. BIRTHPLACE (State or foreign country) Prince Georges Co., Md.; 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Charles Baltimore Calvert; 14. MOTHER'S MAIDEN NAME Eleanor MacKubin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no; (If year, give war or dates of service) —; 16. SOCIAL SECURITY NO. none; 17. INFORMANT Mrs. G. H. Calvert - 1709 P St N.W. Washington, D.C.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic myocardial insufficiency — Interval between onset and death: 2½ months

Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

422.1 (b) Cerebral thrombosis — 1 month

932 (c) Arterio-sclerosis — 4 years

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION none; 19b. MAJOR FINDINGS OF OPERATION —; 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) —; PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY —; (CITY OR TOWN) —; (COUNTY) —; (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) — m.; INJURY OCCURRED While at Work ☐ Not While At work ☐; HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Oct. 10, 1950, to Oct. 20, 1950, that I last saw the deceased alive on Oct. 20, 1950, and that death occurred at 10.50 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Wheeler McArthur - Physician; ADDRESS 7919 Wisconsin Ave, Bethesda, Md.; DATE SIGNED

23. BURIAL, CREMATION / REMOVAL (Specify) Burial; DATE 10/23/50; NAME OF CEMETERY OR CREMATORY Rock Creek; LOCATION (City, town, or county) (State) Washington D.C.

DATE REC'D BY LOCAL REG. 10-21-50; REGISTRAR'S SIGNATURE Helen Kavanagh per K.S.; 24. FUNERAL DIRECTOR James Lee Sons Co; ADDRESS Washington D.C. 300-4th St. N.E.

25693

VS. A15

RECEIVED
OCT 25 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

10355

Reg. Dist. No. 217

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Derwood Md. LENGTH OF STAY (in this place) 8 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Derwood Md.
STREET ADDRESS (If rural give location) —

3. NAME OF DECEASED (Type or Print) (First) RUBY (Middle) LENOR (Last) CARDOZA

4. DATE OF DEATH (Month) Oct. (Day) 31 (Year) 1950

5. SEX FEMALE

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married

8. DATE OF BIRTH Feb. 2-1902

9. AGE last birthday 48 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) West Virginia

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME JOHN H. SOUDER

14. MOTHER'S MAIDEN NAME FRANCELLIA SMITH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, nr unknown) — (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. none

17. INFORMANT Otto C. Cardoza, Derwood, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of Stomach with

151X

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Metastasis

46b

(c)

INTERVAL BETWEEN ONSET AND DEATH 1 yr.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) Frank J. Broschard M.D. ADDRESS Gaithersburg Md DATE SIGNED 11-2-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE THEREOF NOV. 3. 1950 NAME OF CEMETERY OR CREMATORY St. Lukes, Lutheran LOCATION (City, town, nr county) (State) Redland, Md.

DATE REC'D BY LOCAL REG. 11-3-50 REGISTRAR'S SIGNATURE Gertrude B Lawler

24. FUNERAL DIRECTOR Roy W Barber, ADDRESS Laytonsville Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
NOV 8 1950
BUREAU OF

M

10356

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda, Rural
LENGTH OF STAY (in this place) 4 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Virginia COUNTY Prince William
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Quantico
STREET ADDRESS (If rural, give location) 320 4th Avenue ✓

3. NAME OF DECEASED (Type or Print) (First) Eunice (Middle) Mae (Last) CLAY

4. DATE OF DEATH (Month) October (Day) 31, (Year) 1950

5. SEX Female

6. COLOR OR RACE Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH Oct 24, 1928

9. AGE last birthday 22 yrs. If under 1 year Months 00 Days 08 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY - - - - - -

11. BIRTHPLACE (State or foreign country) Virginia

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Clarence HOPKINS

14. MOTHER'S MAIDEN NAME Gussie (Surname unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) - - - -

16. SOCIAL SECURITY NO. - - - - - -

17. INFORMANT AND ADDRESS Husband: Edward CLAY, US Marine Corp Station, Quantico, Va.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Acute cerebral degeneration | 1 wk. |
| 330x Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Hypertension | 7 mo. |
| 83a | (c) Spontaneous subarachnoid hemorrhage | 1 wk. |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Ventriculogram negative

19a. DATE OF OPERATION 28 Oct 50

19b. MAJOR FINDINGS OF OPERATION Hemorrhagic edematous brain

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 28, 1950, to Oct 31, 1950, that I last saw the deceased alive on Oct 31, 1950, and that death occurred at 6:25 P.m., from the causes and on the date stated above.

SIGNATURE B Thomas (Degree or title) ADDRESS DATE SIGNED

B. THOMAS, CDR, MC, USN U.S. NAVAL HOSPITAL November 1, 1950

23. BURIAL, CREMATION REMOVAL (Specify) Removal

DATE THEREOF Nov 1, 1950

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county) (State) Fredericksburg, Virginia

DATE REC'D BY LOCAL REG. Nov 1, 1950

REGISTRAR'S SIGNATURE Edith Whittington

24. FUNERAL DIRECTOR D. M. KAY Funeral Home, D. H. Hale ADDRESS Fredericksburg, Virginia.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15

RECEIVED
NOV 6 1950
BUREAU V. S.

10357

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda, Rural
LENGTH OF STAY (in this place) 22 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Virginia COUNTY Fairfax
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Falls Church
STREET ADDRESS (If rural, give location) 6512 Williston Drive

3. NAME OF DECEASED (Type or Print) (First) Winifred (Middle) Everette (Last) CRAMER

4. DATE OF DEATH (Month) October (Day) 30, (Year) 1950

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Oct 26,1927
9. AGE last birthday 23 yrs. If under 1 year Months 00 Days 05 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY - - - -
11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Harry C. EVERETT
14. MOTHER'S MAIDEN NAME Margaret SHARAR

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) - - - -
16. SOCIAL SECURITY No. - - - - - - -
17. INFORMANT AND ADDRESS Husband: Harold CRAMER

18. MEDICAL CERTIFICATION Same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cirrhosis, liver c̄ ruptured esophageal varices and massive hemorrhage.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

581.0
124 b

INTERVAL BETWEEN ONSET AND DEATH: 1 mo

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes X No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 9, 1950, to Oct 30, 1950, that I last saw the deceased alive on Oct 30, 1950, and that death occurred at 3:58 P m., from the causes and on the date stated above.

SIGNATURE J. G. Hebble III (Degree or title) J.G. HEBBLE, III, CDR, MC, USN ADDRESS U.S. NAVAL HOSPITAL DATE SIGNED October 30,1950

23. BURIAL, CREMATION REMOVAL (Specify) Removal-Burial
DATE THEREOF Oct 30,1950
NAME OF CEMETERY OR CREMATORY Lincoln Cemetery
LOCATION (City, town, or county) (State) Chambersburg, Penn.

DATE REC'D BY LOCAL REG. Oct 30, 1950
REGISTRAR'S SIGNATURE Edith Whittington
24. FUNERAL DIRECTOR J.D. Goshen Funeral Home, ADDRESS Chambersburg, Pennsylvania

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 2 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10358

# CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park
LENGTH OF STAY (in this place) 10 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Sanitarium

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE District Columbia COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington D.C.
STREET ADDRESS (If rural, give location) 4403 Iowa Ave. N.W.

3. NAME OF DECEASED (Type or Print) (First) John (Middle) William (Last) Crouch

4. DATE OF DEATH (Month) October (Day) 5 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH 7-23-74
9. AGE last birthday 76 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home built Carpenter
10b. KIND OF BUSINESS OR INDUSTRY Self Employed
11. BIRTHPLACE (State or foreign country) Fauquier Co. Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Crouch
14. MOTHER'S MAIDEN NAME Elizabeth Thompson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT AND ADDRESS Washington Sanitarium Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Acute Coronary Occlusion | few minutes |
| Antecedent cause(s) | (b) Arteriosclerosis & Hypertension | years |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (c) Hypertrophied prostate & urinary retention | 2 wks. |
| | Thrombotic Hemorrhoids | 10 days |

610X

137a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 10-2-50
19b. MAJOR FINDINGS OF OPERATION Enlarged prostate — ~~Takoma Park — Md~~
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-24, 1950, to 10-5, 1950, that I last saw the deceased alive on 10-5, 1950, and that death occurred at 10:40 a.m., from the causes and on the date stated above.

SIGNATURE John F. Brownsberger (Degree or title) M.D. ADDRESS Takoma Park - Maryland - DATE SIGNED 10-5-50

23. BURIAL, CREMATION REMOVAL (Specify) DATE Oct 9, 1950 NAME OF CEMETERY OR CREMATORY Wash. Natl. Park LOCATION (City, town, or county) Falls Church, Va. (State)

DATE REC'D BY LOCAL REG. 10/5/50. REGISTRAR'S SIGNATURE J. Nelson Dodd
24. FUNERAL DIRECTOR Deal Funeral Home ADDRESS 4812 Ga. Ave. N.W. Wash. D.C.

308V9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 9 1950
BUREAU T. S

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

10359

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH**
COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural- Garret Park
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Rt. 240 Corbys Hill

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE: Maryland — COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: ~~Chevy~~ Chase
STREET ADDRESS (If rural, give location): 7037 Strathmore St.

**3. NAME OF DECEASED (Type or Print)**: (First) CECELIA (Middle) AGNES (Last) DALTON

**4. DATE OF DEATH**: (Month) Oct. (Day) 1, (Year) 1950

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Femele | White | Single | 18April 1911 | 39 yrs. | 5 | 13 | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Health Analyst | US Public Health | New York | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Walter V. Dalton | Alice Dohenney |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|
| No | yes | P.J.Carroll Smithtown Branch Long Island, N.Y. |

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Hemorhage due to Crushed | Sudden |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Skull | death |
| 825.5 170C | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☒ |

| 21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | U.S. Route 240 | near Garrett Park | Monty | Md |

| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at work ☐ Not while at work ☒ | HOW DID INJURY OCCUR? |
|---|---|---|
| Oct 1 50 10 p.m. | | Auto accident |

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Frank J. Broccoli | M.D. | Gaithersburg md | 10-1-50 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial-Transit | 6 Oct. 1950 | St. Patrick's | Smithtown-L.I.New York |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 10-2-50 | Helen Burwell | Robert L. Pumphrey | Bethesda, Md. |

VS. A15A

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RECEIVED
OCT 5 1950
BUREAU V. S

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

10360

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH
COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Olney
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS The Montgomery County General Hospital Inc.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rockville
STREET ADDRESS (If rural, give location) Lincoln Park

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Annie | R. | Davis | October | 15 | 1950 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | Colored | Married | 4/17/15 | 35 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Home | Maryland | U.S.A. |

13. FATHER'S NAME: Melvin T. Jackson

14. MOTHER'S MAIDEN NAME: Charlotte Hose

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| no | XX | Hospital Records |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause (a) | Apoplexy | 1 hr |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) | Chronic nephritis | 3 months |
| (c) | | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☐ |

| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from 9/26, 1950, to 10/15, 1950, that I last saw the deceased alive on 10/14, 1950, and that death occurred at 7:25 A m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| A. D. Bryant | M. D. | Sandy Spring Md. | 10/15/50 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | 10/18/50 | Fisherman Cemetery | Rockville, Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 10-17-50 | Gertrude B Fowler | R. F. Snowden | Rockville, Md |

RECEIVED
OCT 23 1950
BUREAU U. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10361

# CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park
LENGTH OF STAY (in this place) 1½ days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington San & Hosp

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE D.C. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural, give location) 1008 Sigbee Place N.E. ✓

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Henry Baum Davis
4. DATE OF DEATH (Month) (Day) (Year) Oct 31 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH Sept 20, 1871
9. AGE last birthday 79 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10b. KIND OF BUSINESS OR INDUSTRY Architect
11. BIRTHPLACE (State or foreign country) Washington D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William W. Davis
14. MOTHER'S MAIDEN NAME Mary Baum

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Atypical Pneumonia. | 6 Days. |
| 450.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Acute Right Ventricular Failure | Terminal. |
| 109 | (c) Generalized arteriolosclerosis. | 15 yrs. |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1938, to Oct 31, 1950, that I last saw the deceased alive on 10-31, 1950, and that death occurred at 4:12 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Kenneth Vaughan M.D. 8252 Georgia Ave. Silver Spring Md 10-31-50

23. ~~BURIAL~~, CREMATION ~~REMOVAL~~ (Specify) DATE THEREOF 11/2/50 NAME OF CEMETERY OR CREMATORY Hf Lincoln Cem LOCATION (City, town, or county) Pr. Georges Co. (State) Md

DATE REC'D BY LOCAL REG. 10/31/50 REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR S. H. Hines Co. ADDRESS Washington 9 D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 2 1950
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10362

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

**1. PLACE OF DEATH:** C Montgomery Co.

County 5315 - Earlston Drive

City or town West Gate Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 Months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town West Gate Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5315 - Earlston Drive
(If rural, give LOCATION)

2.(a) If veteran, name war No

**3.(a) FULL NAME** Hugh Cecil Davis

**3.(b) Social Security Number** No

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Edith Davis

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 6, 1875

**8. AGE:** Years 75 | Months | Days 11 | If less than one day ..... hrs. ..... min.

9. Birthplace: La Grande Oregon
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: Own business

FATHER
12. Name: Morgan Davis
13. Birthplace: Ill.

MOTHER
14. Maiden name: Henrietta Irwin
15. Birthplace: Ill

16. Informant: Mrs. Edith Davis

Address: 5315 Earlston Drive

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 17, 1950 (month) (day) (year)

Cemetery or crematory: Enterprise Cemetery

Location: Enterprise Oregon

18. Funeral director: Chevy Chase Funeral Home

Address: 5101 - Wisconsin ave Wash. D.C.

19. 10-17-50 19 ..... Helen Kurvach
(Date rec'd by registror) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 10-17- 1950, at 2:36 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 1950 to Sept 20 1950 and that I last saw him alive on Sept 20. 1950

Immediate cause of death: Hypertensive heart disease

Due to: Generalized arteriosclerosis

Due to: 443 L

Other conditions: Ore, 93d
(Include pregnancy within 3 months of death)

DURATION: 10 years

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: C. P. Ryland M D
M. D. or other

Address: 4400 49th St. NW Wash 16 D.C. Date signed 10-17-50

308 V9

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

I talked to Dr Bouchard
regarding this case. he
OKed it.
C Phylund

BUREAU OCT 30 1950

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

10363

Reg. Dist. No. 211

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH
COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Clarksburg
LENGTH OF STAY (In this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Clarksburg
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print): (First) Robert (Middle) Hayden (Last) Davis

4. DATE OF DEATH: (Month) Oct (Day) 3 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: Jan. 28, 1919

9. AGE last birthday: 31 yrs. — If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer, Md. State Road Comm.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Grover C. Davis

14. MOTHER'S MAIDEN NAME: Jessie Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 577-07-0238

17. INFORMANT: Mrs Ella S. Davis, Clarksburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Hemorrhage due to bullet wound — 30 min.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) in st frontal region

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: (CITY OR TOWN) Clarksburg (COUNTY) Monty (STATE) md

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR? self inflicted 22 cal. rifle

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

SIGNATURE: Frank J. Broschart (Degree or title) M.D. ADDRESS: Gaithersburg md DATE SIGNED: 10.3.50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: Oct. 6, 1950
NAME OF CEMETERY OR CREMATORY: Bethesda Methodist
LOCATION (City, town, or county) (State): Browningsville, Md.

DATE REC'D BY LOCAL REG.: Oct. 4, 1950
REGISTRAR'S SIGNATURE: Della N. Burdette
24. FUNERAL DIRECTOR ADDRESS: Olin L. Molesworth, Damascus, Md.

98249

RECEIVED
OCT 9 1980
BUREAU M. S

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

10364

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Scene of Accident

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Kansas — COUNTY Cheyenne
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN St. Francis
STREET ADDRESS (If rural, give location) - - - - - - - - - ✓

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) (Day) (Year) |
|---|---|---|---|
| George | August | Donald DOGGETT | October 24, 1950 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year Months / Days | If under 24 hrs. Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | Aug 13, 1921 | 29 yrs. | 02 12 | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Petty Officer | US Navy | Kansas | US |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| George O. DOGGETT | Rose HESTER |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|
| YES WW II | - - - - - - - - - | U. S. Naval Records |

18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Cerebral hemorrhage due to | sudden |
| 825.5 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) fracture of skull | death. |
| 170c | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☒ No ☐ |

| 21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Highway | (CITY OR TOWN) (COUNTY) (STATE) Bethesda, Montgomery, Maryland |
|---|---|---|
| TIME (Month) (Day) (Year) (Hour) OF INJURY Oct 24,50 m. | INJURY OCCURRED While at work ☐ Not while at work ☒ | HOW DID INJURY OCCUR? Auto Accident |

22. *I certify that I took charge of the remains described above, held an Autopsy* ☒, *Inspection* ☐, *Inquiry* ☐ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☐, *accident* ☒, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|
| Frank J. Broschart Frank J. Broschart, M.D. | Gaithersburg, Maryland | Oct ober 25, 1950 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | Oct 25,1950 | | Goodland, Kansas |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| Oct. 25, 1950 | Edith Whittington | Wastler Funeral Home, 301 East Capitol St., Washington, D.C. |

L. S. P. 60896

RECEIVED
OCT 27 1950
BUREAU

10365

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda, Rural
LENGTH OF STAY (in this place): 15 min.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U. S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Virginia — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Quantico
STREET ADDRESS (If rural, give location): U.S. Marine Corps Station ✓

3. NAME OF DECEASED (Type or Print): (First) (none) (Middle) (none) (Last) DONALDSON

4. DATE OF DEATH: (Month) October (Day) 23, (Year) 19 50

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Oct 23, 1950

9. AGE last birthday: 00 yrs. If under 1 year: Months 00 Days 00 If under 24 hrs.: Hours 00 Min. 15

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): - - - - - -

10b. KIND OF BUSINESS OR INDUSTRY: - - - - - -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Charles G. DONALDSON

14. MOTHER'S MAIDEN NAME: Ruth Ann PRIMEAU

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): - - -

16. SOCIAL SECURITY NO.: - - - - -

17. INFORMANT AND ADDRESS: Mother: Ruth Ann DONALDSON

18. MEDICAL CERTIFICATION: Same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Respiratory failure | 15 min |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) anencephalic monster | |
| | (c) | |

750X
757c

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 23, 1950, to Oct 23, 1950, that I last saw the deceased alive on Oct 23, 1950, and that death occurred at 9:30 P m., from the causes and on the date stated above.

SIGNATURE: C. H. Gilliland — (Degree or title): C. H. GILLILAND, CDR, MC, USN — ADDRESS: U.S. NAVAL HOSPITAL — DATE SIGNED: October 26, 1950

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Disposition | Oct 26, 1950 | USN Medical School | Bethesda, Maryland |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Oct 26, 1950 | Cecil Whittington | None | |

2-0-0-230-21-3-28-2

RECEIVED
OCT 27 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10366

# CERTIFICATE OF DEATH

Reg. Dist. No. 214

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rockville
LENGTH OF STAY (in this place) 9 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Chestnut Lodge Sanitarium

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE District of Columbia; COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural, give location) 2833 29th St. N.W.

3. NAME OF DECEASED (Type or Print): (First) MARY (Middle) ELLEN (Last) DOWLING

4. DATE OF DEATH: (Month) October (Day) 29 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed

8. DATE OF BIRTH: 5/18/68

9. AGE last birthday: 82 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Virginia, U.S.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Fitzgerald

14. MOTHER'S MAIDEN NAME: Fallon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Mrs. M. Z. Wilberding 2833 29th St. N.W.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Arteriosclerotic cardiac disease

420.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Psychosis with cerebral arteriosclerosis

938 (c) Generalized arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): None

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/29, 1950, to 10/29, 1950, that I last saw the deceased alive on October 29, 1950, and that death occurred at 11:35 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Norman C. Puntz M.D. Chestnut Lodge Sanitarium 10/29/50

23. BURIAL, CREMATION REMOVAL (Specify): BURIAL

DATE THEREOF: 11-1-50

NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery

LOCATION (City, town, or county) (State): Washington, D.C.

DATE REC'D BY LOCAL REG. 11-4-50

REGISTRAR'S SIGNATURE: Frances Potter

24. FUNERAL DIRECTOR ADDRESS: Joseph Gawler's Sons 1756 Pa. Ave. N.W.

Joseph Gawler's Sons, Inc D.C.6.

10/29/50 Dr. Broschard notified and will O.K. N.C.R. by F.G.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10367

# CERTIFICATE OF DEATH

Reg. Dist. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park
LENGTH OF STAY (in this place) 29 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Sanitarium and Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE D.C. COUNTY —
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural, give location) 7133 7th St. N.W. ✓

3. NAME OF DECEASED (Type or Print) (First) Alfred (Middle) M. (Last) Eells
4. DATE OF DEATH (Month) October (Day) 31 (Year) 1950
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowered
8. DATE OF BIRTH March 17 1873
9. AGE last birthday 77 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Clay, Iowa
12. CITIZEN OF WHAT COUNTRY? America (USA)
13. FATHER'S NAME Rev. Dudley D. Eells
14. MOTHER'S MAIDEN NAME Mila Cook
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown (If year, give war or dates of service)
16. SOCIAL SECURITY No. —
17. INFORMANT AND ADDRESS Records and Charts of Washington San. and Hosp.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Uremia, terminal, due to | 3 days |
| 583X Antecedent cause(s) | (b) Hepatitis and Cirrhosis, due to | Months? |
| 1246 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (c) Exfoliative dermatitis, unknown etiology | 6 weeks? |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. (a.) Arteriosclerosis generalized with Myocardial infarction and fibrosis. (b) Senile dementia — Mo. to Yrs.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Oct. 26, 1950, to Oct. 31, 1950, that I last saw the deceased alive on October 31, 1950, and that death occurred at 10 21 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Wallace K. Mook M.D. Takoma Park, Md. Nov. 1 1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial — DATE Nov 4 1950 — NAME OF CEMETERY OR CREMATORY Glasgow Cemetery — LOCATION (City, town, or county) (State) Glasgow, Missouri

DATE REC'D BY LOCAL REG. 11/1/50 — REGISTRAR'S SIGNATURE — 24. FUNERAL DIRECTOR ADDRESS J. Arthur Walters, 254 Carroll St NW

VO 894 DC.

RECEIVED
NOV 6 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10368

# CERTIFICATE OF DEATH

Reg. Dist. No. 214

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Montgomery; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Silver Springs; LENGTH OF STAY (in this place): 7 weeks; HOSPITAL OR INSTITUTION OR STREET ADDRESS: Walter Reed Hospital (Forest Glen)

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: District of Columbia; COUNTY: ; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Washington N. W.; STREET ADDRESS (If rural, give location): 233 Whittier Street

3. NAME OF DECEASED (Type or Print): (First) Carroll (Middle) E. (Last) Elmquist

4. DATE OF DEATH: (Month) October (Day) 30 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 31 Jan 1901

9. AGE last birthday: 49 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Air Force Officer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): California

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Gustave Elmquist

14. MOTHER'S MAIDEN NAME: Ida ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If year, give war or dates of service): World Wars I & II

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Mrs. Ida Elmquist, 233 Whittier St, Wash D. C.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Myocardial infarction — Interval Between Onset and Death: None

420.1 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93d. (b) Angina pectoris — 6 mos.

(c) Results of Autopsy: 1. Arteriosclerotic occlusion of right and left coronary arteries.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 2. Arteriosclerotic cardio-vascular disease, severe.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION: None

20. AUTOPSY? Yes ☒ No ☐ See over

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8 May, 1950, to 30 Oct, 1950, that they last saw the deceased alive on 30 Oct, 1950 and that death occurred at 7:25 a.m., from the causes and on the date stated above.

Staff, WRAH pronounced

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Marvin C. Perkins Lt MC Walter Reed Hosp 30 Oct 50

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — DATE: 3 Nov 1950 — NAME OF CEMETERY OR CREMATORY: Arlington National — LOCATION (City, town, or county) (State): Va.

DATE REC'D BY LOCAL REG. 11/1/50 — REGISTRAR'S SIGNATURE: Frances Potter

24. FUNERAL DIRECTOR: The S. H. Hines Co — ADDRESS: 2901 16th St N.W.

11296

Results of autopsy:

1. Arteriosclerotic occlusion of the right and left coronary arteries.

2. Arteriosclerotic cardio-vascular disease, severe.

RECEIVED
NOV 6 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10369

# CERTIFICATE OF DEATH

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
LENGTH OF STAY (in this place) MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN North Chevy Chase
STREET ADDRESS (If rural, give location) 9309 Montgomery Avenue

3. NAME OF DECEASED (Type or Print): (First) Eugene (Middle) James (Last) Fling

4. DATE OF DEATH: (Month) October (Day) 28 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 8/30/1870

9. AGE last birthday: 80 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Capitol Transit Co. Inspector

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Fling

14. MOTHER'S MAIDEN NAME: Truchson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If year, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT AND ADDRESS: Mrs. Lucille Hurlebaus, 9309 Montgomery Ave. North Chevy Chase, Md. - dtr

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 4 Wks.

450.0

Antecedent cause(s)

97

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arterio-sclerosis, generalized — ?

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 1, 1950, to Oct. 28, 1950, that I last saw the deceased alive on Oct. 28, 1950, and that death occurred at 3:15 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) R. H. Warner, M. D. ADDRESS Chevy Chase, Md. DATE SIGNED 10/28/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE: Nov. 1, 1950
NAME OF CEMETERY OR CREMATORY: St. John's Catholic Cemetery
LOCATION (City, town, or county) (State): Forest Glen, Maryland

DATE REC'D BY LOCAL REG. 11-7-50
REGISTRAR'S SIGNATURE: Helen Murnock
24. FUNERAL DIRECTOR: Warner & Pumphrey
ADDRESS: 8434 Ga. Ave., Silver Spring, Maryland

31849

RECEIVED
NOV 10 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

10370

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

Reg. Dist. No. 215

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY Montgomery MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE District of Columbia COUNTY |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda, Rural — LENGTH OF STAY (in this place) 20 days | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital | STREET ADDRESS (If rural, give location) 702 Butternut Street, N.W. |

3. NAME OF DECEASED (Type or Print): (First) John Marshall (Middle) William (Last) FLYNN

4. DATE OF DEATH: (Month) October (Day) 15, (Year) 1950

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year Months | Days | If under 24 hrs. Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Single | May 25, 1925 | 25 yrs. | 04 | 26 | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Petty Officer | US Navy | Massachusetts | US |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| John M. FLYNN | Olive E. RICHARDS |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|---|
| YES | WW II | - - - - - - - | Father: John M. FLYNN |

18. MEDICAL CERTIFICATION Same as item # 2

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| 825.5 Immediate cause | (a) Cerebral hemorrhage due to inter-cranial injury | 23 days |
| 170c Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) | |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☒ No ☐ |
|---|---|---|
| | | |

| 21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY highway | (CITY OR TOWN) Patuxent River | (COUNTY) St Marys | (STATE) Md |
|---|---|---|---|---|
| TIME OF INJURY (Month) (Day) (Year) (Hour) 9-22-50 - 10:45 A m. | INJURY OCCURRED While at work ☐ Not while at work ☒ | HOW DID INJURY OCCUR? auto accident | | |

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Frank J. Broschart<br>Frank J. BROSCHART, M.D. | | Gaithersburg, Maryland | October 15, 1950 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 18, 1950 | Arlington National | Arlington, Virginia |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Oct. 15, 1950 | Edith Whittington | Takoma Funeral Home, 254 Carroll, N.W., Washington, D.C. | |

11296 By [signature]

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
OCT 17 1950
BUREAU T. S

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

10371

Reg. Dist. No. 214

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

**1. PLACE OF DEATH**
COUNTY: Montgomery County - MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN: aod
LENGTH OF STAY (In this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Forest Glen Sec. Walter Reed Army Hosp.

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE: Fla. COUNTY: 381A 2 Trs. - mac Dill A F B
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN:
STREET ADDRESS (If rural give location): Wash 12, D.C.

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Jesse | R | Frusto | Oct | 1 | 1950 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | 1923 | 27 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Airman USAF | USAF | Mexico | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Unknown | Unknown |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|---|
| yes | 1941-1945 1946-To present date | | Records - Walter Reed Hosp. |

**18. MEDICAL CERTIFICATION**

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Asphyxia by hanging | sudden |
| 974X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Suicide | death |
| 164a | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☐ |

| 21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR? | | |

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Frank J. Borchardt | M.D. | Gaithersburg Md | 10-1-50 |

| 23. BURIAL, CREMATION / REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | Oct 2, 1950 | Arlington Nat. Cem. | Arlington Va. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 10/2/50 | Frances Potter | Wastler Funeral Home | 301 E. Capitol St. Wash, D.C. |

V7696

RECEIVED
OCT 4 1960
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10372

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

**1. PLACE OF DEATH:**

County Montgomery

City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
5520-Wisc. Ave.

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5520-Wis ave.
(If rural, give LOCATION)

2.(a) If veteran, name war No

**3. (a) FULL NAME** Henry Samuel Frisbie

**3. (b) Social Security Number** None

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Agnes Virginia

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 18, 1863

8. AGE: Years 87 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace: Mobile Ala.
(Town, county, and state)

10. Usual occupation: Retired - Unk.

11. Industry or business: Government U.S.

FATHER
12. Name: William Frisbie
13. Birthplace

MOTHER
14. Maiden name: Jean D. Plumbe
15. Birthplace: N.J.

16. Informant: Mrs Agnes V. Frisbie
Address: 5520 - Wis ave - NW

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: 10/25/50 (month) (day) (year)

Cemetery or crematory: Oak Hill

Location: Washington D.C.

19. Funeral director: Chevy Chase Funeral Home
Address: 5101-Wis ave. Wash. D.C.

19. 10-23-50 19.....
(Date rec'd by registrar)
Helen Kirwach
Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: October 23 1950, at 3:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 5 1950, to October 23 1950 and that I last saw him alive on October 19, 1950

| Immediate cause of death | DURATION |
|---|---|
| Intra-cerebral hemorrhage | 18 days |
| Due to: Cardio-vascular renal disease | 5 yrs |
| Due to: 442X | |
| Other conditions | |

131a (Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Sidney C. Cousins M.D.
M. D. or other

Address: 3921 Ingomar St. N.W. Date signed: 10-23-50

XVX 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 23 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

10373

Reg. Dist. No. 217

1. PLACE OF DEATH — COUNTY: Montgomery Co MD — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Colesville Md — LENGTH OF STAY (in this place): All Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS: —

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Colesville Md
STREET ADDRESS (If rural, give location): —

3. NAME OF DECEASED (Type or Print): (First) EVAN (Middle) R (Last) Gaither

4. DATE OF DEATH: (Month) Oct. (Day) 24 (Year) 1950

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Oct 20 1869
9. AGE last birthday: 81 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer dg work
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Elizjah Gaither
14. MOTHER'S MAIDEN NAME: Mary Botterill

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If year, give war or dates of service)
16. SOCIAL SECURITY NO.: no
17. INFORMANT AND ADDRESS: Carrie Bell Gaither Colesville Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Heart Block — 10 Min

4262.1 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chr. Myocarditis — 15 yr

93d (c) Senility - Arteriosclerosis — 15 yr

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 1930, to 10 24, 1950, that I last saw the deceased alive on 8 10, 1950, and that death occurred at 11 P m., from the causes and on the date stated above.

SIGNATURE: B. P. Warren (Degree or title) MD — ADDRESS: Laurel Md — DATE SIGNED: 10 24 50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: Oct 27 1950 — NAME OF CEMETERY OR CREMATORY: Emmanuel — LOCATION (City, town, or county) (State): Howard Co Md

DATE REC'D BY LOCAL REG.: 10-26-50 — REGISTRAR'S SIGNATURE: Gertrude B Lawler — 24. FUNERAL DIRECTOR: Roy W. Barber Laytonsville Md — ADDRESS:

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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RECEIVED
NOV 1 1950
BUREAU T. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10374

# CERTIFICATE OF DEATH

Reg. Dist. No. 218

| | |
|---|---|
| 1. PLACE OF DEATH COUNTY: Montg MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE: Maryland COUNTY: Montg |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Gaithersburg — LENGTH OF STAY (in this place): 30yrs | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Gaithersburg |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS: | STREET ADDRESS (If rural, give location): 320 E. Diamond Ave |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) | (First) Annie | (Middle) A. Nelson | (Last) Gartner | 4. DATE OF DEATH | (Month) 10 | (Day) 5 | (Year) 1950 |
| 5. SEX: Female | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married | 8. DATE OF BIRTH: June 6/1893 | 9. AGE last birthday: 57 yrs. | If under 1 year: Months 3, Days 29 | If under 24 hrs.: Hours, Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife & Funeral Director | 10b. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): Goshen Md. | 12. CITIZEN OF WHAT COUNTRY? U S A | | | | |
| 13. FATHER'S NAME: Edward Nelson | 14. MOTHER'S MAIDEN NAME: Rosabell Crawford | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | 16. SOCIAL SECURITY No. | 17. INFORMANT AND ADDRESS: Ernest C. Gartner. Gaithersburg. Md. | | | | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Sub-Arachnoid Hemorrhage — 5 hours

330x

Antecedent cause(s)

83a

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypertension, mild Obesity

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑ |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE) |
| TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from Oct 5, 1950, to Oct 5, 1950, that I last saw the deceased alive on Oct 5, 1950, and that death occurred at 6 15 a.m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Jack Schumacher | M. D. | Gaithersburg, Md. | Oct. 7, 1950 |

| | | | |
|---|---|---|---|
| 23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE: 10/8/50 | NAME OF CEMETERY OR CREMATORY: Forest Oak Cemetery | LOCATION (City, town, or county) (State): Gaithersburg. Md. |
| DATE REC'D BY LOCAL REG. Oct-7, 1950 | REGISTRAR'S SIGNATURE: Alonda G Cooke | 24. FUNERAL DIRECTOR: Ernest C. Gartner. | ADDRESS: Gaithersburg. Md |

V6289

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VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 10 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

10375

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Great Falls
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Potomac River

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE DC; COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural, give location) 3018 Mass. Ave. S.E. ✓

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Roberta | Kay | Gilbert | Oct | 7 | 1950 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| female | white | single | 12-22-1937 | 12 yrs. | | | | |

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): school
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Danville Del.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wm K. Gilbert
14. MOTHER'S MAIDEN NAME: Wilma Dixon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Wm K. Gilbert (father)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| 9276 Immediate cause | (a) Asphyxia by drowning | sudden death |
| 123 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) | |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. ✓
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Potomac R. (CITY OR TOWN): Great Falls (COUNTY): Mont. (STATE): Md
TIME OF INJURY (Month) (Day) (Year) (Hour): Oct 7-50-2:30 p.m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Slipped from rock into River

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title): Frank J. Broccoli M.D. ADDRESS: Gaithersburg Md DATE SIGNED: 10-15-50

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | 10-15-50 | | D.C. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 10-15-50 | Helen Purcell | Martin W. Hyson Co. | 1300 N St. N.W. Wash., D.C. |

VS. A15A

RECEIVED
OCT 17 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10376

# CERTIFICATE OF DEATH

Reg. Dist. No. 214

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN KENSINGTON; MARYLAND; LENGTH OF STAY (in this place) 14 YRS; HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MD; COUNTY MONTGOMERY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN KENSINGTON; STREET ADDRESS (If rural, give location) 4301 - BROOKFIELD DRIVE

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| MR. ROBERT | STEWART | GOURLAY | 10 | 5 | 1950 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | | 11-25-83 | 66 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| ENGINEER | Marine Eng | GREENOCK, SCOTLAND | U. S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| MR. ROBERT STEWART GOURLAY | AGNES GRIEVE |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| NO | 578-03-5680 | MRS. C. G. FAIRALL 106 GLENRIDGE ST KENSINGTON, MD. |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Carcinomatosis | 1 yr. |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Carcinoma of prostate gland | 1½ Yrs. |
| | (c) | |

177X
51b

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☒ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) | (Day) | (Year) | (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|---|---|---|
| | | | m. | | |

22. I hereby certify that I attended the deceased from Nov., 1949, to Oct 5, 1950, that I last saw the deceased alive on Oct 5, 1950, and that death occurred at 11:45 a.m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Stewart McAfee | M. D. | 3921 Ingomar St. Wash. D.C. | Oct 5 1950 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 9, 1950 | Ft. Lincolnview. | Prince Geo Co Md |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 10/6/50 | Frances Porter | S. H. Hines Co | 2901-14th St. N.W. |

RECEIVED
OCT 11 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10377

# CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gaithersburg
STREET ADDRESS (If rural, give location) R.F.D. # 3

3. NAME OF DECEASED (Type or Print) (First) Sallie (Middle) Waters (Last) Gray
4. DATE OF DEATH (Month) Oct. (Day) 22 (Year) 1950

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow
8. DATE OF BIRTH June 10, 1861
9. AGE last birthday 89 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Newport, Kentucky
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Henry Waters
14. MOTHER'S MAIDEN NAME Mary Cornelia Gaither

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS William H. Waters, Great nephew

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Acute peritonitis — INTERVAL BETWEEN ONSET AND DEATH 36 hours

153X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Intestinal obstruction from Carcinoma of rectum.

46d (c) Colostomy

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senility.

19a. DATE OF OPERATION 21 Oct. 1950
19b. MAJOR FINDINGS OF OPERATION Obstruction sigmoid flexure, colon
20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at 8:36 P.m., from the causes and on the date stated above.

SIGNATURE William C. Miller, M.D. (Degree or title) ADDRESS 7-Brooke Ave., Gaithersburg, Maryland DATE SIGNED 10-23-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 10/25/50
NAME OF CEMETERY OR CREMATORY Goshen Cemetery
LOCATION (City, town, or county) Goshen Md (State)

DATE REC'D BY LOCAL REG. Oct 23, 1950
REGISTRAR'S SIGNATURE Alvada L Cooke
24. FUNERAL DIRECTOR E. C. Gaither ADDRESS Gaithersburg Md

M

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VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 25 1950
BUREAU V. B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10378

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH: COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda, Rural
LENGTH OF STAY (in this place) 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Virginia — COUNTY Fairfax
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annandale, Rural
STREET ADDRESS (If rural, give location) Route # 1 ✓

3. NAME OF DECEASED (Type or Print): (First) Edith (Middle) Raymond (Last) GUTHRIE

4. DATE OF DEATH: (Month) October (Day) 22, (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Sept 8, 1877

9. AGE last birthday: 73 yrs. If under 1 year: Months 01 Days 13 If under 24 hrs.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: - - - - - -

11. BIRTHPLACE (State or foreign country): New Jersey

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Clarence RAYMOND

14. MOTHER'S MAIDEN NAME: Catherine LANSING

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) - - - - -

16. SOCIAL SECURITY NO. - - - - - - -

17. INFORMANT AND ADDRESS: Son: John J. GUTHRIE

18. MEDICAL CERTIFICATION: Same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Thrombosis — Interval between onset and death: 3 days

420.1 Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive Cardiovascular Disease — 4 yrs

93d (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 21, 1950 to Oct 22, 1950, that I last saw the deceased alive on Oct 22 1950, and that death occurred at 10:45 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) J. W. FLYNN, LTJG, MC, USN — ADDRESS U.S. NAVAL HOSPITAL — DATE SIGNED October 23, 1950

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF Oct. 26, 1950 | NAME OF CEMETERY OR CREMATORY Arlington National | LOCATION (City, town, or county) (State) Arlington, Virginia

DATE REC'D BY LOCAL REG. Oct 23, 1950 | REGISTRAR'S SIGNATURE Elsie Whittington

24. FUNERAL DIRECTOR — ADDRESS R. A. Pumphrey, 7557 Wisconsin Avenue, Bethesda, Maryland.

RECEIVED
OCT 25 1950
BUREAU V. S

FILM No. G 129 NOV 20 1950

For Cause of Death ams

MARYLAND STATE DEPARTMENT OF HEALTH

10379

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
LENGTH OF STAY (in this place) 4 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 5201 Glenwood Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Monty
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
STREET ADDRESS (If rural give location) 5201 Glenwood Rd.

3. NAME OF DECEASED (Type or Print) (First) Robin (Middle) Lee (Last) Hamilton
~~Fischer~~ ~~Reid~~ ~~Hyde~~

4. DATE OF DEATH (Month) Oct (Day) 16 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Singer
8. DATE OF BIRTH 6-9-50
9. AGE last birthday yrs. If under 1 year Months 4 Days 7 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) D.C.
12. CITIZEN OF WHAT COUNTRY? M.S.A

13. FATHER'S NAME Howard Kemper Hyde (Foster Father)
14. MOTHER'S MAIDEN NAME Sara Marie Black (Foster Mother)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Howard Kemper Hyde (Foster Father)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Asphyxia ~~[illegible]~~

754.4 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Autopsy: Congenital heart disease.

157 e (No evidence to support suffocation)

(c) (11-20-50 - ams)

INTERVAL BETWEEN ONSET AND DEATH: Found dead in bed.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) Bethesda (COUNTY) Mont. (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE Frank J. Broschart (Degree or title) M.D. ADDRESS Gaithersburg Md DATE SIGNED 10-16-50

23. BURIAL, CREMATION REMOVAL (Specify) DATE THEREOF 10-19-50 NAME OF CEMETERY OR CREMATORY Washington National Cemetery LOCATION (City, town, or county) Suitland (State) Md.

DATE REC'D BY LOCAL REG. 10-17-50 REGISTRAR'S SIGNATURE Helen Kurvack
24. FUNERAL DIRECTOR Chambers Funeral Home ADDRESS 1400 Chapin St., N.W., Wash. D.C.

9V6-09-0-99V99V

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
OCT 20 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

10380

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

Reg. Dist. No. 223

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park
LENGTH OF STAY (In this place) 9 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Wash. San. & Hosp

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Monty
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
STREET ADDRESS (If rural give location) 301 Brewster Ave

3. NAME OF DECEASED (Type or Print) (First) Rose (Middle) (Last) Harris

4. DATE OF DEATH (Month) Oct (Day) 11 (Year) 1950

5. SEX Female
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow
8. DATE OF BIRTH about 1879 ~~unknown~~
9. AGE last birthday 71 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Lithuania
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Hosp. Rec

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Respiratory failure due to

INTERVAL BETWEEN ONSET AND DEATH

491X Immediate cause (a) Bronchitis, Chronic mucous purulent
Bronchopneumonia, acute resolving — 9 days

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)
107
(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Fell from hosp. bed. Autopsy showed no fracture of cerebral or meningeal injury — 10-4-50

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) Tak Pk (COUNTY) Mont (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE Frank J. Broschart (Degree or title) M.D. ADDRESS Gaithersburg Md DATE SIGNED 10-12-50

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) DATE THEREOF Oct 14-50 NAME OF CEMETERY OR CREMATORY Mt Judah Cemet Lhland LOCATION (City, town, or county) (State) N.Y.

DATE REC'D BY LOCAL REG. 10/12/50 REGISTRAR'S SIGNATURE J. Wilson Dodd
24. FUNERAL DIRECTOR B. Danzansky & Son ADDRESS 3541-14 St N.W. Wash. D.C.

902.7

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
OCT 10 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

10381

Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BETHESDA
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS SUBURBAN HOSPITAL 3600 OLD GEORGETOWN ROAD

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Damascus
STREET ADDRESS (If rural, give location) none

3. NAME OF DECEASED (Type or Print) (First) Mattie (Middle) Lee (Last) Hill

4. DATE OF DEATH (Month) 10 (Day) 18 (Year) 1950

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH Sept-2-1868
9. AGE last birthday 82 yrs. If under 1 year Months 1 Days 16 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hwy
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) McCracken County, Kentucky
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME not known
14. MOTHER'S MAIDEN NAME not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO. no
17. INFORMANT AND ADDRESS Son - Robert Lee Hill

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) cerebral embolus

Antecedent cause(s) (b) intertrochanteric fracture rt femur — 2 weeks

900.0 1860

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 10/8/50
19b. MAJOR FINDINGS OF OPERATION fracture, rt femur
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home
(CITY OR TOWN) Damascus (COUNTY) (STATE) Md.
TIME OF INJURY (Month) 10 (Day) 6 (Year) 50 (Hour) 6:00 p.m.
INJURY OCCURRED While at Work ☐ Not While At work ☒
HOW DID INJURY OCCUR? fall down steps

22. I hereby certify that I attended the deceased from 10-6-, 1950, to 10-18, 1950, that I last saw the deceased alive on 10/18, 1950, and that death occurred at 7:00 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) D. L. Marks, M.D.
ADDRESS 6306 Wisconsin Ave
DATE SIGNED Chevy Chase, Md

23. BURIAL, CREMATION REMOVAL (Specify) Burial-Transit
DATE 19Oct.1950
NAME OF CEMETERY OR CREMATORY McKendrey Church Cem.
LOCATION (City, town, or county) Paducah, Kentucky (State)

DATE REC'D BY LOCAL REG. 10-19-50
REGISTRAR'S SIGNATURE Helen Kurvaed
24. FUNERAL DIRECTOR Robert H. Humphrey
ADDRESS Bethesda, Md.

M

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 23 1950
BUREAU V. I.

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

10382

Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rockville Rural
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Near Garrett Park

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Washington, D.C. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington, D.C.
STREET ADDRESS (If rural give location) 4547 MacArthur Blv'd.

3. NAME OF DECEASED (Type or Print) (First) Joseph (Middle) H (Last) Hughes

4. DATE OF DEATH (Month) Oct (Day) 23 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH 4 June 1884
9. AGE last birthday 66 yrs. If under 1 year Months 4 Days 19 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur
10b. KIND OF BUSINESS OR INDUSTRY Convalescent Home
11. BIRTHPLACE (State or foreign country) Mass.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 101-03-2042
17. INFORMANT Richard C. Smith

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) coronary occlusion — sudden

420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) — death.

9.1a (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) Frank J. Broschart M.D.
ADDRESS Gaithersburg Md
DATE SIGNED 10-23-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial Transit
DATE THEREOF 24 Oct. 1950
NAME OF CEMETERY OR CREMATORY Evergreen Cemetery
LOCATION (City, town, or county) Kings County (State) N.Y.

DATE REC'D BY LOCAL REG. 10-24-50
REGISTRAR'S SIGNATURE Helen Kurvack
24. FUNERAL DIRECTOR Robert A. Pumphrey
ADDRESS Bethesda, Md.

42092

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

I

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OCT 27 1950
BUREAU

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10383

# CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda, Rural
LENGTH OF STAY (in this place) 5 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. NAVAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE District of Columbia; COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural, give location) 247 12th Street, S.E. ✓

3. NAME OF DECEASED (Type or Print): (First) James (Middle) Richard (Last) HURDLE

4. DATE OF DEATH: (Month) October (Day) 4, (Year) 19 50

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: June 15, 1889

9. AGE last birthday: 61 yrs. If under 1 year: Months 05 Days 20 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Baker

10b. KIND OF BUSINESS OR INDUSTRY: Bakery

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Richard HURDLE

14. MOTHER'S MAIDEN NAME: Mary SIMPSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW I

16. SOCIAL SECURITY NO. - - - - - -

17. INFORMANT AND ADDRESS: Brother: Thomas B. HURDLE, 1516 E St. S.E., Washington, DC

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0 Immediate cause (a) Thrombosis, Coronary Artery — Interval between onset and death: 30 min

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

93d (b) Arteriosclerotic Heart Disease — 15 years

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 30 19 50, to Oct 4, 19 50, that I last saw the deceased alive on Oct 4, 19 50, and that death occurred at 8:30 P.m., from the causes and on the date stated above.

SIGNATURE A. E. MARLAND, LTJG, MC, USN (Degree or title) ADDRESS U.S. NAVAL HOSPITAL DATE SIGNED October 5, 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: Oct 9 1950
NAME OF CEMETERY OR CREMATORY: Arlington National
LOCATION (City, town, or county) (State): Arlington, Virginia

DATE REC'D BY LOCAL REG. Oct. 5, 1950
REGISTRAR'S SIGNATURE Elsie Whittington

24. FUNERAL DIRECTOR ADDRESS: R.A. Mattingly, 131 11th Street, S.E., Washington, D.C. W. F. Malloy

RECEIVED
OCT 2 1981
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

10384

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 214

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring; LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 9011 - First Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Montg.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
STREET ADDRESS (If rural, give location) 9011 - First St.

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Charles | Henry | James | 10 | 16 | 1950 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | | Jan 20, 1870 | 80 yrs. | | | | |

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Shoe Salesman
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Cleveland, Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Thomas James
14. MOTHER'S MAIDEN NAME: Anna Vickers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: ?
17. INFORMANT AND ADDRESS: George T. James (Nephew)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Acute Cardiac failure | 1 day. |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Arteriosclerotic Heart Disease | ? |
| | (c) | |

420.0
93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☒ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from Oct. 16, 1950, to Oct. 16, 1950 that I last saw the deceased alive on Oct. 16, 1950, and that death occurred at 9:00 P.M., from the causes and on the date stated above.

| SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|
| J. Marion Bamford M.D. | 9601 Sutton Pl. Silver Spring Md. | 10/16/50 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-19-50 | Lake View Cemetery | Cleveland Ohio |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 10/17/50 | Frances Potter | The S. H. Hines Co. | 2901-14th St. N.W. Washington 9, D.C. |

27884

Dr. F. J. Broschardt (County Medical Examiner) notified. He O.K'd issuance of this certificate

J Marion Bankhead

10385

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park
LENGTH OF STAY (in this place) 5 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Sanitarium

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park
STREET ADDRESS (If rural, give location) 307 Carroll Ave.

3. NAME OF DECEASED (Type or Print) (First) Philmore (Middle) Edgar (Last) Johnson
4. DATE OF DEATH (Month) Oct. (Day) 7 (Year) 1950
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH 2-26-91
9. AGE last birthday 59 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Station agent
10b. KIND OF BUSINESS OR INDUSTRY B & O Railroad
11. BIRTHPLACE (State or foreign country) Mt. Sidney Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William H. Johnson
14. MOTHER'S MAIDEN NAME Ida E. Moore
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS Washington Sanitarium Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Cerebral Hemorrhage | Terminal |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Hypertension | years |
| | (c) Arteriosclerosis | years |

331X
83a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/31/, 1950, to 10/7/, 1950, that I last saw the deceased alive on 10/7/, 1950, and that death occurred at 9:05 a.m., from the causes and on the date stated above.

SIGNATURE Robert A Hare MD. (Degree or title) ADDRESS Takoma Park, Md. DATE SIGNED 10/7/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial.
DATE THEREOF 10/10/50
NAME OF CEMETERY OR CREMATORY Old Stone Church Cem.
LOCATION (City, town, or county) (State) Ft. Defiance, Augusta Va.
DATE REC'D BY LOCAL REG. Oct 8 1950
REGISTRAR'S SIGNATURE J. Hilton Dodd
24. FUNERAL DIRECTOR J. Arthur Walters, 254 Carroll St NW DC ADDRESS

24447

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 11 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

10386

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH**
COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rockville
LENGTH OF STAY (In this place): 5 mos
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 1107 Rockville Pike

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural give location): Valley Road

**3. NAME OF DECEASED (Type or Print)**: (First) Stella (Middle) Johnson (Last)

**4. DATE OF DEATH**: (Month) Oct (Day) 9 (Year) 1950

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Married | 9/2/1898 | 52 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Harmon, W. Va. | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Not Known | Alice Wilfong |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|
| No | None | Gilbert E. Johnson |

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

331X **Immediate cause** (a) Cerebral Hemorrhage — 6 hrs.

83a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) ____

(c) Hypertension — 2 yrs

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☒ |

| 21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I certify that I took charge of the remains described above, held an Autopsy* ☐, *Inspection* ☒, *Inquiry* ☐ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Fred J. Bouchat | M.D. | Gaithersburg Md | 10-9-50 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Transit Burial | 10/9/50 | Hillcrest Cemetery | Cumberland | Maryland |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 10-[illegible]-50 | Helen Kurwash | John Hafer | Cumberland, Md. |

VS. A15A

RECEIVED
OCT 13 1960
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

10387

Reg. Dist. No. 217

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Olney
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS The Montgomery County General Hospital Inc.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Zion
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Philip (Middle) (Last) Jones

4. DATE OF DEATH (Month) October (Day) 30 (Year) 1950

5. SEX Male

6. COLOR OR RACE Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single

8. DATE OF BIRTH Oct. 23, 1877

9. AGE last birthday 73 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer

10b. KIND OF BUSINESS OR INDUSTRY Houseman

11. BIRTHPLACE (State or foreign country) Maryland.

12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME Philip Jones

14. MOTHER'S MAIDEN NAME Hannah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. None

17. INFORMANT Laura Miller ( Sister )

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

151 X Immediate cause (a) Carcinoma gastric ?

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

46 b (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 1947

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from October 16 1950, to Oct 30, 1950, that I last saw the deceased alive on Oct 28, 1950, and that death occurred at 6:48 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Webster Sewell, M.D. ADDRESS Norbeck DATE SIGNED Nov. 1 1950

23. BURIAL CREMATION REMOVAL (Specify) DATE THEREOF 11/2/1950 NAME OF CEMETERY OR CREMATORY Lincoln Park, LOCATION (City, town, or county) Rockville, Md. (State)

DATE REC'D BY LOCAL REG. 11-2-50 REGISTRAR'S SIGNATURE Gertrude B Lawler

24. FUNERAL DIRECTOR Robert L. Snowden ADDRESS

52086

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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NOV 8 1950
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MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

10388

Reg. Dist. No. 215

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda, Rural; LENGTH OF STAY (In this place) 25 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. NAval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Prince Georges; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hyattsville; STREET ADDRESS (If rural, give location) 4100 Crittenden Street

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Charles | Austin | KETCHAM | October. | 31, | 1950 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | Sept 9, 1875 | 75 yrs. | 01 | 23 | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Not known | - - - - - - | New York | US |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| George KETCHAM | Elizabeth AUSTIN |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY No. | 17. INFORMANT |
|---|---|---|---|
| YES | WW I | - - - - - - - | Wife: Charlotte KETCHAM |

18. MEDICAL CERTIFICATION — Same as item # 2

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Pulmonary embolis | 30 min. |
| 903.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Thrombo-phlebitis left femoral vein | unknown |
| 856a | (c) Fracture left tibia (accidental) | 24 days |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☒ No ☐ |

| 21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | Home | Hyattsville, Md. | | |

| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| Oct. 7, 1950 m. | | Fall. (11-29-50 - ams) |

22. *I certify that I took charge of the remains described above, held an Autopsy* ☒, *Inspection* ☐, *Inquiry* ☐ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Frank J. Broschart, M.D. | | Gaithersburg, Maryland | November 1, 1950 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-6-50 | Arlington National | Arlington, Virginia |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 1, 1950 | Edith Whittington | Gasch's Funeral Home, 4739 Baltimore Avenue, Hyattsville, Md. |

XV X99

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
NOV 6 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10389

# CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH: COUNTY Montgomery Co. — Joliffe Nursing Home — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Colesville
LENGTH OF STAY (in this place) 1 YR 22 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY MONT. CO.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN KENSINGTON, MD.
STREET ADDRESS (If rural, give location) 9571 WEST STANHOPE RD.

3. NAME OF DECEASED (Type or Print): (First) Charles (Middle) (Last) Kiester

4. DATE OF DEATH: (Month) 10 (Day) 23 (Year) 1950

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W

8. DATE OF BIRTH: DEC. 25, 1863

9. AGE last birthday: 86 yrs. If under 1 year: Months 9 Days 28 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Station Agent, Ches. N. & W. R. R.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): DIXON - ILL.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: AUGUSTUS KIESTER

14. MOTHER'S MAIDEN NAME: AMELIA KOLB

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: NURSING HOME RECORDS

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cardiac Dilatation — Interval Between Onset and Death: about 3 days

422.1 93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arterio-sclerosis (Myocarditis)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Slight Hemiplegia 2 yrs. ago

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-12, 19 50 to 10.18, 19 50 that I last saw the deceased alive on 10, 18, 19 50., and that death occurred at 5 23 P.M., from the causes and on the date stated above.

SIGNATURE Caryl Bernard (Degree or title) ADDRESS 1801 Eye St DATE SIGNED 10, 23, 50

23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF 10/25/50 NAME OF CEMETERY OR CREMATORY Garden Prairie LOCATION (City, town, or county) (State) Garden Prairie Ill.

DATE REC'D BY LOCAL REG. 10/23/50 REGISTRAR'S SIGNATURE Frances Potter

24. FUNERAL DIRECTOR ADDRESS Wm. S. H. Hines Co. 2901 14th. St. N.W. WASH. D.C.

9444

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 27 1950
BUFFALO N. Y.

M

MARYLAND STATE DEPARTMENT OF HEALTH

10390

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
LENGTH OF STAY (in this place) few min.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Suburban Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE D.C. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural, give location) 4054 Hessenden Ave

3. NAME OF DECEASED (Type or Print) (First) Mary (Middle) R. (Last) Klaphaak
4. DATE OF DEATH (Month) Oct (Day) 1 (Year) 1950
5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow
8. DATE OF BIRTH 4-23-97
9. AGE last birthday 53 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk
10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.
11. BIRTHPLACE (State or foreign country) Pa
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Peter John
14. MOTHER'S MAIDEN NAME Mary T. Roberts
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT David Klaphaak

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| 420.1 Immediate cause | (a) Coronary occlusion | 2½ hr. |
| 94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) | |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE Frank J. Broschart M.D. (Degree or title) ADDRESS Gaithersburg Md DATE SIGNED 10-1-50

23. BURIAL, CREMATION REMOVAL (Specify) Cremation
DATE THEREOF Oct 2 1950
NAME OF CEMETERY OR CREMATORY Ceder Hill
LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG. 10-2-50
REGISTRAR'S SIGNATURE Helen Kurvach
24. FUNERAL DIRECTOR Cherry Chase Fun. Home ADDRESS 5101 Wisconsin

26697

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15A

RECEIVED
OCT 5 1950
BUREAU V. S.

10391

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Montgomery — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda, (Rural)
LENGTH OF STAY (in this place): 47 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: USNH, Bethesda, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: District of Columbia — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Washington
STREET ADDRESS (If rural, give location): 1208 Shephard St., NW,

3. NAME OF DECEASED (Type or Print): (First) Marcus (Middle) Samuel (Last) KOCH

4. DATE OF DEATH: (Month) Oct (Day) 21 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: Wh

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 7 Jun 1900

9. AGE last birthday: 50 yrs. If under 1 year: Months 05 Days 14 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Jewler

10b. KIND OF BUSINESS OR INDUSTRY: Own business

11. BIRTHPLACE (State or foreign country): Ohio

12. CITIZEN OF WHAT COUNTRY: U.S.

13. FATHER'S NAME: Samuel Koch

14. MOTHER'S MAIDEN NAME: Belle Fruhauf

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WWII

16. SOCIAL SECURITY NO.: - - - - - -

17. INFORMANT AND ADDRESS: Wife: Genevieve Koch-same as Block 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

157X Immediate cause (a) Carcinoma, pancreas with widespread metastasis — Interval between onset and death: 7 mths.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
469 (b)
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes [X] No [ ]

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:
(CITY OR TOWN) (COUNTY) (STATE):
TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
INJURY OCCURRED While at Work [ ] Not While At work [ ]:
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sep 4, 1950, to Oct 21, 1950, that I last saw the deceased alive on 21 Oct, 1950, and that death occurred at 1:40 p.m., from the causes and on the date stated above.

SIGNATURE: R. J. Mc Carthy — (Degree or title): LTJG MC USN — ADDRESS: USNH, Bethesda, Maryland — DATE SIGNED: 21 Oct 50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: Oct 24/1950
NAME OF CEMETERY OR CREMATORY: Forrest Oaks
LOCATION (City, town, or county) (State): Gaithersburg, Md.

DATE REC'D BY LOCAL REG.: Oct 21, 1950
REGISTRAR'S SIGNATURE: Edith Wolfington
24. FUNERAL DIRECTOR ADDRESS: SHINES FUNERAL Home 2901 14th St., Washington, D. C. U.S.A.

OCT 24 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

10392

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 223-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

**1. PLACE OF DEATH**
COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Takoma Park
LENGTH OF STAY (in this place): 23hrs. 10min.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Washington Sanitarium and Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE: District of Columbia — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Washington, D.C.
STREET ADDRESS (If rural, give location): 509 Peabody St. N.W. Apt. #4

**3. NAME OF DECEASED** (Type or Print): (First) Nora (Middle) Elizabeth (Last) Lavender

**4. DATE OF DEATH**: (Month) Oct. (Day) 15 (Year) 1950

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Fe | White | Widow | 8-21-72 | 78 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House wife | | Boston Mass. | U.S. |

**13. FATHER'S NAME**: (First unknown) Driscoll

**14. MOTHER'S MAIDEN NAME**: Nora Delacy

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) (If year, give war or dates of service)

**16. SOCIAL SECURITY NO.**

**17. INFORMANT AND ADDRESS**: Patient's chart

**18. MEDICAL CERTIFICATION**

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Diabetic Coma | 2 Days. |
| Antecedent cause(s) | (b) Diabetes Mellitus | 14 yrs. |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (c) Generalized arteriosclerosis | 15 yrs. |

260X
61

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☐ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from Nov, 1936, to Oct 15, 1950, that I last saw the deceased alive on Oct 15, 1950, and that death occurred at 9:50 P. m., from the causes and on the date stated above.

SIGNATURE: Kenneth Laughlin (Degree or title) M.D. ADDRESS: 8252 Georgia Ave Silver Spring Md DATE SIGNED: 10-16-50

| 23. BURIAL, CREMATION / REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/18/50 | Mt Olivet Cem. | Washington D.C. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 10/16/50 | J. Watkins Dodd | F. J. Collins - Wash. D.C. | 3821-14 St. N.W. |

RECEIVED
OCT 18 1950
BUREAU T. S

Items 4, 13, 14: letter from Dr. Allen filmed 10-12-50 - 6128-11

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10393

# CERTIFICATE OF DEATH

Reg. Dist. No. 214

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH**
COUNTY: Montgomery — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Kensington
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 10403 Warner Ave.

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE: Maryland — COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Kensington
STREET ADDRESS (If rural, give location): 10403 Warner Ave.

**3. NAME OF DECEASED** (Type or Print): (First) Hugh (Middle) A (Last) Lawlor

**4. DATE OF DEATH**: (Month) ~~Sept.~~ Oct. (Day) ~~30~~ 2 (Year) 1950

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | widowed | 3/5/1886 | 64 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Bartender | | New York, New York | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| J. Lawlor, Wm J. | Jane Barry |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| no | 578-10-1213 | John Conrad Lawlor-10403 Warner Ave. Kensington, Md. |

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| **Immediate cause** | (a) Cirrhosis of the Liver Chronic Fever | 6 months |
| 450.0 **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. 61 | (b) Arteriosclerosis Marked | yrs. |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus Chronic mod

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐ |
|---|---|---|
| | | |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from MAY, 19....., to 1950, 19....., that I last saw the deceased alive on 9/30/50, 19....., and that death occurred at 5:30 A.M. m., from the causes and on the date stated above.

SIGNATURE: Samuel Adams (Degree or title) ADDRESS: Kensington Md DATE SIGNED: 10/2/50

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 4, 1950 | Ft. Lincoln Cemetery | Prince George Co. Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 10/3/50 | Frances Potter | Warmer & Pumphrey, | 8434 Ga. Ave., Silver Spring Md. |

VS. A15

7071

RECEIVED
OCT 4 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

10394

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Montgomery — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda, Rural
LENGTH OF STAY (in this place): 29 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: District of Columbia — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Washington
STREET ADDRESS (If rural, give location): 56 Defress Street, NW ✓

3. NAME OF DECEASED (Type or Print): (First) James (Middle) Edward (Last) LITTLETON

4. DATE OF DEATH: (Month) October (Day) 29, (Year) 19 50

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Oct 14, 1898

9. AGE last birthday: 52 yrs. — If under 1 year: Months 00 Days 16 — If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer-General

10b. KIND OF BUSINESS OR INDUSTRY: Various

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Oscar LITTLETON

14. MOTHER'S MAIDEN NAME: Jennie (Surname unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WW I II

16. SOCIAL SECURITY NO.: - - - - - -

17. INFORMANT AND ADDRESS: Wife: Alverta LITTLETON

18. MEDICAL CERTIFICATION — Same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

151x Immediate cause (a) Generalized carcinomatosis — Interval between onset and death: unknown

46b Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Carcinoma of stomach — unknown

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 1, 1950, to Oct 29, 1950, that I last saw the deceased alive on Oct 29, 1950, and that death occurred at 7:25 P m., from the causes and on the date stated above.

SIGNATURE: R. B. Speaker — (Degree or title): LTJG, MC, USN — ADDRESS: U.S. NAVAL HOSPITAL — DATE SIGNED: October 30, 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Nov 2, 1950 — NAME OF CEMETERY OR CREMATORY: Arlington National — LOCATION (City, town, or county) (State): Arlington, Virginia

DATE REC'D BY LOCAL REG.: Oct 30, 1950 — REGISTRAR'S SIGNATURE: Cecil Whittington

24. FUNERAL DIRECTOR — ADDRESS: Malvan & Schey, 424 R Street, NW, Washington, D. C.

RECEIVED
NOV 2 1950
BUREAU U. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10395

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY: Montgomery; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda; LENGTH OF STAY (in this place): 3½ days; HOSPITAL OR INSTITUTION OR STREET ADDRESS: Suburban Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Silver Spring; STREET ADDRESS (If rural, give location): 308 Timberwood Ave.

3. NAME OF DECEASED (Type or Print): (First) VIRTYE (Middle) REBECCA (Last) MACKALL

4. DATE OF DEATH: (Month) Oct. (Day) 18 (Year) 1950

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed

8. DATE OF BIRTH: July 6, 1872

9. AGE last birthday: 78 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: David F. Penington

14. MOTHER'S MAIDEN NAME: Mary Alverta Snyder

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Mrs. Reba Needham (daughter)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X

Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset and Death: 3 days

83a

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension — 3-4 yrs

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1948, to Oct 18, 1950, that I last saw the deceased alive on Oct 17, 1950, and that death occurred at 4:52 A.m., from the causes and on the date stated above.

SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED

William D. Aud, M.D | Silver Spring, Md | 18 Oct 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: 10/21/50 | NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery | LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE REC'D BY LOCAL REG.: 10/20/50 | REGISTRAR'S SIGNATURE: Helen Kurvack | 24. FUNERAL DIRECTOR: Warner E. Lumpkins | ADDRESS: 8434 Ga. Ave., Silver Spring, Maryland

RECEIVED
OCT 24 1950
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10396

# CERTIFICATE OF DEATH

Reg. Dist. No. 223

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY Montgomery — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park — LENGTH OF STAY (in this place) 14 hr.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Sanitarium

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Cordie (Middle) Harris (Last) Mann

4. DATE OF DEATH: (Month) October (Day) 15 (Year) 1950

5. SEX: Male — 6. COLOR OR RACE: White — 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed — 8. DATE OF BIRTH: October 14, 1888 — 9. AGE last birthday: 62 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Supt. of Scales — 10b. KIND OF BUSINESS OR INDUSTRY: Southern Railway — 11. BIRTHPLACE (State or foreign country): Missouri — 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank Mann — 14. MOTHER'S MAIDEN NAME: Sarah Pugh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO. — 17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Acute Pulmonary Edema — 1 day

434.3 / 95C

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chronic Heart Failure — about 8 years

(c) Cor Pulmonale — 8 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/3/50, to 10/15/50, that I last saw the deceased alive on 10/14/50, and that death occurred at 5:30 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

Benjamin Pearson, M.D. — 7896 Georgia Ave Silver Spring, Md — 10/15/50

23. BURIAL / CREMATION / REMOVAL (Specify) — DATE THEREOF 10/18/50 — NAME OF CEMETERY OR CREMATORY Cedar Hill Cem — LOCATION (City, town, or county) Ft Foster Tn. (State) Md.

DATE REC'D BY LOCAL REG. 10/15/50 — REGISTRAR'S SIGNATURE J Wilson Dodd — 24. FUNERAL DIRECTOR The S.H. Hines Co. — ADDRESS 2901 14TH ST. N.W. WASHINGTON D.C.

VS. A15

496 47

RECEIVED
OCT 18 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10397

# CERTIFICATE OF DEATH

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda, Rural
LENGTH OF STAY (in this place): 8 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Chevy Chase
STREET ADDRESS (If rural, give location): 6 West Blackthorn Street

3. NAME OF DECEASED (Type or Print): (First) Anita (Middle) Cussen (Last) MARSTELLER

4. DATE OF DEATH: (Month) October (Day) 14, (Year) 19 50

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: July 8, 1887

9. AGE last birthday: 63 yrs. — If under 1 year: Months 03 Days 07 — If under 24 hrs.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: - - - - -

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: William J. CUSSEN

14. MOTHER'S MAIDEN NAME: Marie P. SMITH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service): - - -

16. SOCIAL SECURITY NO.: - - - - - -

17. INFORMANT AND ADDRESS: Husband: Aclpfar A. MARSTELLER

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

175X Immediate cause (a) Carcinomatosis — Same as item # 2 — Interval between onset and death: 16 Mo.

49a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Carcinoma, Ovary — 20 Mo

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 14, 1950, to Oct 14, 1950, that I last saw the deceased alive on Oct 14, 1950, and that death occurred at 2:50 A m., from the causes and on the date stated above.

SIGNATURE L. M. Harris (Degree or title) ADDRESS DATE SIGNED

L. M. HARRIS, CAPT, MC, USN — U.S. NAVAL HOSPITAL — October 14, 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: Oct. 17, 1950

NAME OF CEMETERY OR CREMATORY: Arlington National

LOCATION (City, town, or county) (State): Arlington, Virginia

DATE REC'D BY LOCAL REG.: Oct. 14, 1950

REGISTRAR'S SIGNATURE: Edith W. Ellington

24. FUNERAL DIRECTOR ADDRESS: Robert A. Pumphrey, RPC, 7557 Wisconsin Avenue, Bethesda, Maryland.

RECEIVED
OCT 16 1950
BUREAU

10398

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rockville
LENGTH OF STAY (in this place) 70 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 229 W. Montgomery Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rockville
STREET ADDRESS (If rural, give location) 229 W. Montgomery Ave.

3. NAME OF DECEASED (Type or Print) (First) Theodore (Middle) Simpson (Last) Mason
4. DATE OF DEATH (Month) Oct. (Day) 5 (Year) 1950
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH 10 July 1875
9. AGE last birthday 75 yrs. If under 1 year Months 2 Days 25 If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Banker
10b. KIND OF BUSINESS OR INDUSTRY Banking Cashier - Hamilton Nat. Bank
11. BIRTHPLACE (State or foreign country) Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Enoch W. Mason
14. MOTHER'S MAIDEN NAME Mary Bell Simpson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No
16. SOCIAL SECURITY No. 577-22-1695
17. INFORMANT AND ADDRESS Sarah C. Mason- 229 W. Montgomery Ave. Rockville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinomatosis of liver & peritoneum, probably primary in pancreas

157X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

46g (c)

INTERVAL BETWEEN ONSET AND DEATH: 8 months

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION none
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 25, 1950, to Oct. 5, 1950, that I last saw the deceased alive on Oct. 5, 1950, and that death occurred at 10 29 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Wm A. Linthicum, M.D. ADDRESS Rockville, Md. DATE SIGNED 10/5/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 7 Oct 1950
NAME OF CEMETERY OR CREMATORY Rockville Union Ceme.
LOCATION (City, town, or county) Rockville, (State) Maryland
DATE REC'D BY LOCAL REG. 10-6-50
REGISTRAR'S SIGNATURE Peggy Veazey
24. FUNERAL DIRECTOR Robert A. Humphrey ADDRESS Bethesda, Md.

1568V

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

M

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RECEIVED
OCT 9 1950
BUREAU V. S

NAMES: certificate of birth. 10-30-50 L

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10399

# CERTIFICATE OF DEATH

Reg. Dist. No. 223-

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park,
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington San. & Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
STREET ADDRESS (If rural, give location) 2009 Race Church Rd.

3. NAME OF DECEASED (Type or Print) (First) Unnamed (Middle) Baby (Last) McKenna REGINA

4. DATE OF DEATH (Month) 10 (Day) 14 (Year) 1950

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Newborn

8. DATE OF BIRTH 10-14-50

9. AGE last birthday yrs. If under 1 year Months Days If under 24 hrs. Hours 4 Min. 44

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Marylan

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John Edw. McKenna

14. MOTHER'S MAIDEN NAME Louise Pfeiffer (Louise Regina

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS Mother - 2009 Race Church R. Silver Sp. Md

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH.

INTERVAL BETWEEN ONSET AND DEATH

754.4 **Immediate cause** (a) Congenital Heart Disease 4hr 24 min

157e **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/14, 1950, to 10/14, 1950, that I last saw the deceased alive on 10/14, 1950, and that death occurred at 7:50 PM m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Paul Haak M.D. ADDRESS 8801 Colesville Rd. Silver Spring, Md. DATE SIGNED 10/14/50

23. BURIAL, CREMATION / REMOVAL (Specify) Burial

DATE THEREOF 10/16/50

NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery

LOCATION (City, town, or county) (State) Washington, D. C.

DATE REC'D BY LOCAL REG. 10/15/50

REGISTRAR'S SIGNATURE J. Allan Dodd

24. FUNERAL DIRECTOR Warner & Pumphrey, ADDRESS 8434 Ga. Ave., Silver Spring, Maryland

2-0-0-14-6-94-1-40-5

RECEIVED
OCT 17 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

10400

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A16

1. PLACE OF DEATH
COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda, Rural
LENGTH OF STAY (in this place): 7 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Silver Spring
STREET ADDRESS (If rural, give location): 8205 Grubb Road

3. NAME OF DECEASED (Type or Print): (First) Evelyn (Middle) Fay (Last) McNERNEY

4. DATE OF DEATH: (Month) October (Day) 13, (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: July 30, 1905

9. AGE last birthday: 45 yrs. — If under 1 year: Months 02 Days 14 — If under 24 hrs.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: - - - - -

11. BIRTHPLACE (State or foreign country): Connecticut

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: John FAY

14. MOTHER'S MAIDEN NAME: Mary RUSHFORD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service): - - - -

16. SOCIAL SECURITY NO.: - - - - - -

17. INFORMANT AND ADDRESS: Husband: John C. McNERNEY

18. MEDICAL CERTIFICATION: Same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Intracranial metastases — Interval Between Onset and Death: 6 wks.

170X

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Carcinoma of Breast — 27 mo

50

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 7, 1950, to Oct 13, 1950, that I last saw the deceased alive on Oct 13, 1950, and that death occurred at 1:40 P m., from the causes and on the date stated above.

SIGNATURE: B Thomas — (Degree or title): B. THOMAS, CDR, MC, USN — ADDRESS: U.S. NAVAL HOSPITAL — DATE SIGNED: October 13, 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Removal — DATE THEREOF: Oct 13, 1950 — NAME OF CEMETERY OR CREMATORY: St. Thomas — LOCATION (City, town, or county) (State): Southington, Conn.

DATE REC'D BY LOCAL REG.: Oct. 13, 1950 — REGISTRAR'S SIGNATURE: Edith Whittington

24. FUNERAL DIRECTOR — ADDRESS: R. A. Pumphrey, 7557 Wisconsin Avenue, Bethesda, Maryland.

RECEIVED
OCT 16 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

10401

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda, Rural
LENGTH OF STAY (in this place) 15 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Kansas — COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Independence
STREET ADDRESS (If rural, give location) 201 South 6th Street ✓

3. NAME OF DECEASED (Type or Print): (First) Herbert (Middle) Alton (Last) MEYER

4. DATE OF DEATH: (Month) October (Day) 2, (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Aug 30, 1886

9. AGE last birthday: 64 yrs. — If under 1 year: Months 01 Days 03 — If under 24 hrs.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Publisher

10b. KIND OF BUSINESS OR INDUSTRY: Newspaper

11. BIRTHPLACE (State or foreign country): Ohio

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: John MEYER

14. MOTHER'S MAIDEN NAME: Louise GRESHAM

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW I

16. SOCIAL SECURITY NO. - - - - - -

17. INFORMANT AND ADDRESS: Wife: Mary MEYER

18. MEDICAL CERTIFICATION: Same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 **Immediate cause** (a) MYOCARDIAL INFARCTION

94a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) CORONARY THROMBOSIS

(c) CORONARY ARTERIOSCLEROSIS

INTERVAL BETWEEN ONSET AND DEATH

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? XXXXX No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 18, 1950, to Oct 2, 1950, that I last saw the deceased alive on Oct 2, 1950 and that death occurred at 6:35 P m., from the causes and on the date stated above.

SIGNATURE I. L. V. NORMAN, CAPT, MC, USN (Degree or title) U.S. NAVAL HOSPITAL (ADDRESS) October 3, 1950 (DATE SIGNED)

23. BURIAL, CREMATION REMOVAL (Specify) Removal

DATE THEREOF Oct 3, 1950

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county) (State) Independence, Kansas

DATE REC'D BY LOCAL REG. Oct. 3, 1950

REGISTRAR'S SIGNATURE Edith Worthington

24. FUNERAL DIRECTOR S. H. Hines, ADDRESS 2901 14th Street, NW, Washington, D.C. Mrs Mitchell

15614

RECEIVED
OCT 5 1950
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

10402

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda, Rural
LENGTH OF STAY (in this place) 1 mo 25 da
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE District of Columbia; COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural, give location) 5175 Branch Avenue, S.E.

3. NAME OF DECEASED (Type or Print): (First) John (Middle) William (Last) MUSSON

4. DATE OF DEATH: (Month) October (Day) 1, (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Mar 6, 1900

9. AGE last birthday: 50 yrs. If under 1 year: Months 06 Days 26 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Auditor

10b. KIND OF BUSINESS OR INDUSTRY: US Gov't

11. BIRTHPLACE (State or foreign country): District of Columbia

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: PoyntonMUSSON

14. MOTHER'S MAIDEN NAME: Emma CALDWELL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW I II

16. SOCIAL SECURITY No.

17. INFORMANT AND ADDRESS: Wife: Mary E. MUSSON

18. MEDICAL CERTIFICATION: Same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

162X Immediate cause (a) Bronchogenic carcinoma with

47C Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) metastases to brain & kidney — Interval between onset and death: 6 mos

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 9, 1950 to Oct 1, 1950, that I last saw the deceased alive on Oct 1, 1950 and that death occurred at 2:27 P m., from the causes and on the date stated above.

SIGNATURE: P. W. Willis III (Degree or title) P. W. WILLIS, III, LTJG, MCR, USNR ADDRESS US NAVAL HOSPITAL DATE SIGNED October 2, 1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: Oct 5, 1950

NAME OF CEMETERY OR CREMATORY: Arlington National

LOCATION (City, town, or county) (State): Arlington, Virginia

DATE REC'D BY LOCAL REG.: Oct. 2, 1950

REGISTRAR'S SIGNATURE: Edith Worthington

24. FUNERAL DIRECTOR ADDRESS: W. W. Chambers, 517 11th Street, S.E. Washington, D.C.

11277

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OCT 4 1990
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10403

# CERTIFICATE OF DEATH

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda, Rural — LENGTH OF STAY (in this place) 4 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE District of Columbia — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural, give location) 501 G Street, S.E. ✓

3. NAME OF DECEASED (Type or Print): (First) Daniel (Middle) James (Last) NELSON

4. DATE OF DEATH: (Month) October (Day) 15, (Year) 1950

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Feb. 8, 1895

9. AGE last birthday: 55 yrs. — If under 1 year: Months 08 Days 08 — If under 24 hrs.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fireman

10b. KIND OF BUSINESS OR INDUSTRY: US Gov't

11. BIRTHPLACE (State or foreign country): South Carolina

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Daniel NELSON

14. MOTHER'S MAIDEN NAME: Anna May FRENCHES

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.: - - - - - -

17. INFORMANT AND ADDRESS: Wife: Alice R. NELSON

18. MEDICAL CERTIFICATION: Same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| 759.0 Immediate cause | (a) Empyema, pleura | 2 week |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 1100 | (b) Abscess, pulmonary | 2 week |
| | (c) Congenital cystic disease of lung | years |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes X No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 12, 1950 to Oct 15, 1950, that I last saw the deceased alive on Oct 15 1950, and that death occurred at 8:30 P m., from the causes and on the date stated above.

SIGNATURE P. W. Willis III (Degree or title) ADDRESS DATE SIGNED

P. W. WILLIS, III, LTJG, MCR, USNR U.S. NAVAL HOSPITAL October 16, 1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: Oct. 19 1950 | NAME OF CEMETERY OR CREMATORY: Arlington National | LOCATION (City, town, or county) (State): Arlington, Virginia

DATE REC'D BY LOCAL REG.: Oct. 16, 1950 | REGISTRAR'S SIGNATURE: Enid Whittington

24. FUNERAL DIRECTOR: Hall Bros. Funeral Home, 621 Florida Ave., NW, Washington, D.C. — ADDRESS: 9th & Hall

VS. A15

RECEIVED
OCT 18 1950

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

10404

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda, Rural
LENGTH OF STAY (in this place) 1 mo 17 da
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE District of Columbia — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural, give location) 4478 Fort Drive S.E. ✓

3. NAME OF DECEASED (Type or Print): (First) Warren (Middle) Edward (Last) NUTT

4. DATE OF DEATH: (Month) October (Day) 8, (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Sept 13, 1902

9. AGE last birthday: 48 yrs. If under 1 year: Months 00 Days 26 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Auditor

10b. KIND OF BUSINESS OR INDUSTRY: US Gov't

11. BIRTHPLACE (State or foreign country): Indiana

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Elliott NUTT

14. MOTHER'S MAIDEN NAME: Alice SUTTON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES ✓ (If yes, give war or dates of service) WW II

16. SOCIAL SECURITY NO. - - - - -

17. INFORMANT AND ADDRESS: Wife: Mary E. NUTT

18. MEDICAL CERTIFICATION: Same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Myocardial failure

420.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) arteriosclerotic heart disease

90d (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Post pneumonectomy, rt.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 22, 1950, to Oct 8, 1950, that I last saw the deceased alive on Oct 8, 1950, and that death occurred at 12:55 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or Title) ADDRESS DATE SIGNED

R. E. HERMANN, LTJG, MCR, USNR — U.S. NAVAL HOSPITAL — October 9, 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Oct. 11, 1950 — NAME OF CEMETERY OR CREMATORY: Arlington National — LOCATION (City, town, or county) (State): Arlington, Virginia

DATE REC'D BY LOCAL REG.: Oct. 9, 1950 — REGISTRAR'S SIGNATURE: Edith Whittington

24. FUNERAL DIRECTOR — ADDRESS: W. W. Chambers, 517 11th Street, S.E. Washington, D.C. R.D.2.

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OCT 10 1950
BUREAU V. S

10405

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gaithersburg
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Gaither Rest Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Montg.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gaithersburg
STREET ADDRESS (If rural, give location) R.F.D.

3. NAME OF DECEASED (Type or Print) (First) Mary Margaret (Middle) Miller (Last) Pennifield

4. DATE OF DEATH (Month) Oct (Day) 15 (Year) 1950

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH July 31 1866
9. AGE last birthday 84 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY Housewife
11. BIRTHPLACE (State or foreign country) Gaithersburg Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Joseph McCrossin
14. MOTHER'S MAIDEN NAME Louise Disney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Clara Everhart Sister

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) La Grippe | 8 days |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Cardio-nephritis | 2 months |
| | (c) Senility - arteriosclerosis, senile dementia | 4 years |

481x
131a

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-29-, 1950, to 10-15-, 1950, that I last saw the deceased alive on 10-15-, 1950, and that death occurred at 3 15 p m., from the causes and on the date stated above.

SIGNATURE William C. Miller (Degree or title) MD ADDRESS 7 Brooks Ave., Gaithersburg, Md DATE SIGNED 10-16-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Oct 16 1950
NAME OF CEMETERY OR CREMATORY Forrestown Church
LOCATION (City, town, or county) Montg. Co. (State) Md

DATE REC'D BY LOCAL REG. Oct. 16, 1950
REGISTRAR'S SIGNATURE Alsuda G. Cooke
24. FUNERAL DIRECTOR Robert A. Pumphrey ADDRESS Rockville Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15 T

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OCT 18 1950
BUREAU V *

10406

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 223

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Takoma Park
LENGTH OF STAY (in this place): 7da 10½hrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Washington Sanitarium and Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Silver Spring
STREET ADDRESS (If rural, give location): 200 Hartwell Rd.

3. NAME OF DECEASED (Type or Print): (First) Rose (Middle) Libby (Last) Pepperman

4. DATE OF DEATH: (Month) 10 (Day) 2 (Year) 1950

5. SEX: Fe

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 3-8-89

9. AGE last birthday: 61 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): New York New York U.S.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Louis Lippmann

14. MOTHER'S MAIDEN NAME: Sarah (unKnown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY No.:

17. INFORMANT AND ADDRESS: Patient's chart

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) — Metastatic Carcinoma — Interval Between Onset and Death: about 6 months

154X Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

46 (b) Carcinoma — Recto Sigmoid — 16 months

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: Oct 6 - 1949

19b. MAJOR FINDINGS OF OPERATION: adenocarcinoma of Colon

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/28, 1949, to 10/2, 1950, that I last saw the deceased alive on 10/2, 1950, and that death occurred at 7:04 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Benjamin Isaacson, M.D. 7846 Georgia Ave. Silver Spring Md Oct 2 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Oct-4-50 — NAME OF CEMETERY OR CREMATORY: Mt Zion Ave — LOCATION (City, town, or county) (State): Maspeth Long Island N.Y.

DATE REC'D BY LOCAL REG.: 10/2/50 — REGISTRAR'S SIGNATURE: J. Milton Dodd

24. FUNERAL DIRECTOR: B Dampnsky & Son — ADDRESS: 350-14th St N.W. Washington D.C.

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OCT 6 1950
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10407

# CERTIFICATE OF DEATH

Reg. Dist. No. 214

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rockville; LENGTH OF STAY (in this place) 3 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS Chestnut Lodge Sanitarium

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Florida; COUNTY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Coral Gables; STREET ADDRESS (If rural, give location) 350 Riviera Drive ✓

3. NAME OF DECEASED (Type or Print): (First) Kate (Middle) Baldwin (Last) Phillips

4. DATE OF DEATH: (Month) October (Day) 20 (Year) 1950

5. SEX: F.

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH: April 30 1863

9. AGE last birthday: 87 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Otego, N.Y.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME: Sally Beardslee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknowo) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Walter Garey 204 Oakwood Ave. Elmira N.Y.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Myocardial Coronary Disease — Interval Between Onset and Death: 8-10 yrs.

420.1 94a

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or coodition causing death. Generalized arteriosclerosis Malnutrition of Psychiatric Origin

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 1, 1950, to Oct 20, 1950, that I last saw the deceased alive on Oct 20, 1950 and that death occurred at 2:33 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Travis Kasle M.D. Chestnut Lodge, Rockville Md. 10-20-50

23. BURIAL, CREMATION REMOVAL (Specify): Cremation

DATE THEREOF: 10/21/50

NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory

LOCATION (City, town, or couoty) (State): Suitland, Maryland

DATE REC'D BY LOCAL REG. 10/20/50

REGISTRAR'S SIGNATURE: Frances Cotter

24. FUNERAL DIRECTOR ADDRESS: Joseph Gawler's Sons 1756 Pa. Ave Wash. D. C.

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OCT
1958

MARYLAND STATE DEPARTMENT OF HEALTH

10408

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 215

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda, Rural
LENGTH OF STAY (in this place) 8 mo 19 da
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Virginia; COUNTY Arlington
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Arlington
STREET ADDRESS (If rural, give location) 3540 South Utah Street

3. NAME OF DECEASED (Type or Print): (First) Alberta (Middle) Madaline (Last) PICKEN

4. DATE OF DEATH: (Month) October (Day) 18, (Year) 19 50

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Sept 4, 1908

9. AGE last birthday: 42 yrs. If under 1 year: Months 01 Days 15 If under 24 hrs.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: - - - -

11. BIRTHPLACE (State or foreign country): Alberta, Canada

12. CITIZEN OF WHAT COUNTRY? Not known

13. FATHER'S NAME: William SNIDER

14. MOTHER'S MAIDEN NAME: Mary ALGER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) - - - -

16. SOCIAL SECURITY NO. - - - - - - -

17. INFORMANT AND ADDRESS: Husband: James C. PICKEN

18. MEDICAL CERTIFICATION: Same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

581.0 Immediate cause (a) acute and chronic Peritonitis

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

120.6 (b) Acute pyelonephritis

(c) Portal Cirrhosis

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes X No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 30, 1950, to Oct 18, 1950, that I last saw the deceased alive on Oct 18, 1950, and that death occurred at 10:30 A m., from the causes and on the date stated above.

SIGNATURE AND (Degree or title) S. H. OLIVER, CDR, MC, USN ADDRESS U.S. NAVAL HOSPITAL DATE SIGNED October 19, 1950

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF Oct 23, 1950 | NAME OF CEMETERY OR CREMATORY Arlington National | LOCATION (City, town, or county) (State) Arlington, Virginia

DATE REC'D BY LOCAL REG. Oct. 19, 1950 | REGISTRAR'S SIGNATURE Edith Whittington

24. FUNERAL DIRECTOR ADDRESS S. H. Hines, 2901 14th Street, NW, Washington, D. C. (S.P.)

VS: A15

RECEIVED
OCT 23 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10409

# CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Chevy Chase
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 5612 Wisconsin Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE D.C. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural, give location) 1330 Belmont Street, N.W. ✓

3. NAME OF DECEASED (Type or Print) (First) Harvey (Middle) C. (Last) Pierce
4. DATE OF DEATH (Month) (Day) (Year) Oct 28, 1950 19

5. SEX M
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widower
8. DATE OF BIRTH Nov, 5 1857
9. AGE last birthday 92 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired auditor Treasurer
10b. KIND OF BUSINESS OR INDUSTRY Dept U.S. Govt.
11. BIRTHPLACE (State or foreign country) Ill.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Jas. H. Pierce
14. MOTHER'S MAIDEN NAME Rachel Raed

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS Jas H. Pierce (Son)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|---|
| 332X | Immediate cause | (a) Cerebral thrombosis | 7 weeks |
| 83b | Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) General arteriosclerosis | Indefinite |
| | | (c) | |

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION none
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) none
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 7, 1950, to Oct 28, 1950, that I last saw the deceased alive on Oct. 27, 1950, and that death occurred at 12.55 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Henry C. Macatee M.D. ADDRESS 1746 K St. N.W. Washington DC DATE SIGNED Oct 28, 1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 10-31-50
NAME OF CEMETERY OR CREMATORY
LOCATION (City, town, or county) (State) Columbia Ga.

DATE REC'D BY LOCAL REG. 10-28-50
REGISTRAR'S SIGNATURE Helen Kurvack
24. FUNERAL DIRECTOR The S. H. Hines Co. ADDRESS 2901-14th st N.W.

11297

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

RECEIVED
OCT 31 1950
BUREAU OF

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10410

# CERTIFICATE OF DEATH

Reg. Dist. No. 223

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park | LENGTH OF STAY (in this place) 10 hours
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Sanitarium Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE D.C. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural, give location) 527 4th St. S.W. ✓

3. NAME OF DECEASED (Type or Print): (First) Francis (Middle) Theodore (Last) Port
4. DATE OF DEATH: (Month) October (Day) 3 (Year) 1950

5. SEX: M
6. COLOR OR RACE: White
7. (SINGLE) MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH: 4-19-82
9. AGE last birthday: 68 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lawyer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Washington D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Joseph Port
14. MOTHER'S MAIDEN NAME: Mary Theresa Hoffman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or (unknown)) (If year, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT AND ADDRESS: Hospital Record furnished by deceased

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Occlusion — 12 hours

420.1 Antecedent cause(s)

94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? Cleared with Coroner.

22. I hereby certify that I attended the deceased from 10/3/, 1950, to 10/3, 1950, that I last saw the deceased alive on 10/3/, 1950, and that death occurred at 8:30P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Robert A Stare M.D. Takoma Park, Md. 10/4/50

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify) | DATE oct 6 1950 | NAME OF CEMETERY OR CREMATORY St. Marys Cemetery | LOCATION (City, town, or county) Wash. (State) D.C.

DATE REC'D BY LOCAL REG. 10/4/50 | REGISTRAR'S SIGNATURE J. Wilbur Dodd | 24. FUNERAL DIRECTOR Robert A. Mattingly | ADDRESS 131-11th St. S.E. Wash. D.C.

23613

RECEIVED
OCT 9 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

10411

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

Reg. Dist. No. 214

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

**1. PLACE OF DEATH**
COUNTY: Montgomery
STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Silver Spring
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 1609 Ballard Street

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE: Maryland
COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Silver Spring
STREET ADDRESS (If rural give location): 1609 Ballard Street

**3. NAME OF DECEASED** (Type or Print): ~~Mrs.~~ Lucy P. Powell

**4. DATE OF DEATH**: Oct. 14 1950

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)**: Widowed

**8. DATE OF BIRTH**: Jan. 30, 1877

**9. AGE last birthday**: 73 yrs.
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Homemaker

**10b. KIND OF BUSINESS OR INDUSTRY**: Own home

**11. BIRTHPLACE** (State or foreign country): Tennessee

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: John R. Porter

**14. MOTHER'S MAIDEN NAME**: Rosia Rucker

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): no
(If yes, give war or dates of service):

**16. SOCIAL SECURITY NO.**: none

**17. INFORMANT**: Mrs. Martha P. Brasch - daughter

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 **Immediate cause** (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden

94a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) sudden death
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION**:
**19b. MAJOR FINDINGS OF OPERATION**:
**20. AUTOPSY?** Yes ☐ No ☐

**21. EXTERNAL CAUSE WAS** PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:
(CITY OR TOWN) (COUNTY) (STATE):
TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?:

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: Frank J. Brasch M.D. (Degree or title) ADDRESS: Gaithersburg Md DATE SIGNED: 10-14-50

**23. BURIAL, CREMATION, REMOVAL** (Specify): Burial
DATE THEREOF: 10/16/50
NAME OF CEMETERY OR CREMATORY: Brookeville M.E. Cemetery
LOCATION (City, town, or county) (State): Montgomery County, Maryland

DATE REC'D BY LOCAL REG. 10/15/50
REGISTRAR'S SIGNATURE: Frances Potter

**24. FUNERAL DIRECTOR** ADDRESS: Warner E. Pumphrey, 8434 Ga. Ave. Silver Spring, Maryland

RECEIVED
OCT. 20 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10412

# CERTIFICATE OF DEATH

Reg. Dist. No. 214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 723 Richmond Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
STREET ADDRESS (If rural, give location) 723 Richmond Ave.

3. NAME OF DECEASED (Type or Print): (First) Charles (Middle) (Last) Price

4. DATE OF DEATH: (Month) Oct. (Day) 24 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 2/28,1885

9. AGE last birthday: 65 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Worked in pool room

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Olney, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Price

14. MOTHER'S MAIDEN NAME: Elizabeth Day

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Mrs. Edna L. Price-723 Richmond Ave. Silver Spring, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Gastric Hemorrhage | 24 hrs. |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Cirhosis of Liver | 1 yr. |
| | (c) Syphilis | 2 yrs. |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | Subliminal Diabetes Mellitus | 2 yrs. |

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec., 1948, to Oct., 1950; that I last saw the deceased alive on 10-23, 1950, and that death occurred at 10A m., from the causes and on the date stated above.

SIGNATURE L. B. Snow (Degree or title) M.D. ADDRESS Silver Spring, Md. DATE SIGNED 10/24/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: 10/26/50

NAME OF CEMETERY OR CREMATORY: Colesville Cemetery

LOCATION (City, town, or county) (State): Colesville Maryland

DATE REC'D BY LOCAL REG. 10/25/50

REGISTRAR'S SIGNATURE Frances Potter

24. FUNERAL DIRECTOR: Warner & Pumphrey ADDRESS: 8434 Ga. Ave., Silver Spring Maryland

RECEIVED
OCT 27 1950
BUREAU Y. S

MARYLAND STATE DEPARTMENT OF HEALTH

10413

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 211

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH**
COUNTY: MONTGOMERY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: HYATTSTOWN
LENGTH OF STAY (in this place): 35 YRS.
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE: MARYLAND — COUNTY: MONTGOMERY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Hyattstown
STREET ADDRESS (If rural, give location):

**3. NAME OF DECEASED (Type or Print)**: (First) CHARLES (Middle) JASPER (Last) PRICE

**4. DATE OF DEATH**: (Month) 10 (Day) 23 (Year) 1950

**5. SEX**: MALE

**6. COLOR OR RACE**: WHITE

**7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)**: MARRIED

**8. DATE OF BIRTH**: 11-3-1885

**9. AGE last birthday**: 64 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

**10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)**:

**10b. KIND OF BUSINESS OR INDUSTRY**: UNEMPLOYED

**11. BIRTHPLACE (State or foreign country)**: MARYLAND

**12. CITIZEN OF WHAT COUNTRY?**: U.S.

**13. FATHER'S NAME**: CHARLES PRICE

**14. MOTHER'S MAIDEN NAME**: SARAH WARFIELD DAY

**15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)**: NO
(If year, give war or dates of service):

**16. SOCIAL SECURITY NO.**: NONE

**17. INFORMANT AND ADDRESS**: JOE W. PRICE HYATTSTOWN MD.

**18. MEDICAL CERTIFICATION**

**I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH**

Immediate cause (a): Chronic Myocarditis

Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b):
(c):

422.2
93d

INTERVAL BETWEEN ONSET AND DEATH:

**II. OTHER SIGNIFICANT CONDITIONS**
Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION**:

**19b. MAJOR FINDINGS OF OPERATION**:

**20. AUTOPSY?** Yes ☐ No ☒

**21. ACCIDENT / SUICIDE / HOMICIDE (Specify)**:

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

**22.** I hereby certify that I attended the deceased from 8/1, 1950 to 10/23, 1950 that I last saw the deceased alive on 10/23, 1950, and that death occurred at 8:30 P. m., from the causes and on the date stated above.

SIGNATURE: H. Thresher (Degree or title) ADDRESS: Frederick Md. DATE SIGNED:

**23. BURIAL, CREMATION ~~REMOVAL~~ (Specify)**: BURIAL

DATE: 10-25-1950

NAME OF CEMETERY OR CREMATORY: MT. OLIVET

LOCATION (City, town, or county): FREDERICK (State): MD.

DATE REC'D BY LOCAL REG.: 24 Oct. 1950

REGISTRAR'S SIGNATURE: Della W. Burdette

**24. FUNERAL DIRECTOR** ADDRESS: W.L. Burdette, Hyattstown, Md.

XVL 44

RECEIVED
OCT 30 1950
BUREAU V. S

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10414

# CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda, Rural
LENGTH OF STAY (in this place) 20
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE District of Columbia COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural, give location) 5208 MacArthur Blvd.

3. NAME OF DECEASED (Type or Print) (First) Herman (Middle) Harvell (Last) PRIETO

4. DATE OF DEATH (Month) October (Day) 6, (Year) 1950

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single

8. DATE OF BIRTH Aug. 31, 1894

9. AGE last birthday 56 yrs. If under 1 year Months 01 Days 06 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer

10b. KIND OF BUSINESS OR INDUSTRY Construction

11. BIRTHPLACE (State or foreign country) New York

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Harvell PRIETO

14. MOTHER'S MAIDEN NAME Sarah (Surname unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW I

16. SOCIAL SECURITY NO. - - - - - - -

17. INFORMANT AND ADDRESS Friend: Mrs. Kathryn MECHEM

18. MEDICAL CERTIFICATION Same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Pulmonary Infarction, right upper lobe | 24 hours |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Thrombophlebitis, right lower extremity | 20 days |
| | (c) Rheumatic Heart Disease | 30 years |

416X
95b

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 17, 1950, to Oct 6, 1950, that I last saw the deceased alive on Oct. 6, 1950, and that death occurred at 6:15 A.m., from the causes and on the date stated above.

SIGNATURE A. E. Marland (Degree or title) ADDRESS DATE SIGNED
A. E. MARLAND, LTJG, MC, USN U.S. NAVAL HOSPITAL October 6, 1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF Oct 10, 1950

NAME OF CEMETERY OR CREMATORY Arlington National

LOCATION (City, town, or county) (State) Arlington, Virginia

DATE REC'D BY LOCAL REG. Oct. 6, 1950

REGISTRAR'S SIGNATURE Edith Whittington

24. FUNERAL DIRECTOR ADDRESS W. W. Chambers, 3072 M Street, NW, Washington, D.C.

P.J.K.

306 V9

RECEIVED
OCT 9 1950
BUREAU

10415

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 223

| | |
|---|---|
| 1. PLACE OF DEATH COUNTY Montgomery MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Montgomery |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park — LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS 1001 Flower Ave. | STREET ADDRESS (If rural, give location) 1001 Flower Avenue |

3. NAME OF DECEASED (Type or Print) (First) Elmer (Middle) E (Last) Quackenbush — 4. DATE OF DEATH (Month) Oct. (Day) 5, (Year) 1950

5. SEX Male — 6. COLOR OR RACE White — 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married — 8. DATE OF BIRTH 9-7-1879 — 9. AGE last birthday 71 yrs. — If under 1 year Months. Days — If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber — 10b. KIND OF BUSINESS OR INDUSTRY Retired — 11. BIRTHPLACE (State or foreign country) Spring Valley, New York — 12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME Wm. Ethan Allen Quackenbush — 14. MOTHER'S MAIDEN NAME Caroline Rose

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If year, give war or dates of service) — 16. SOCIAL SECURITY No. — 17. INFORMANT AND ADDRESS Mrs. Julia Quackenbush, 1001 Flower Ave. Tak. Park Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.0 Immediate cause (a) Coronary Occlusion — 15 min.

Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerotic heart disease — 2 1/2 yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diverticulosis of the Sigmoid — 2 yrs 5 mo.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 14, 1948, to Sept. 28, 1950, that I last saw the deceased alive on Sept. 28, 1950, and that death occurred at 9:15 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Wallace N. Mook M.D. 805 Carroll Ave. Takoma Pk., Md. 10-5-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial — DATE Oct. 7, 1950 — NAME OF CEMETERY OR CREMATORY George Washington Cemetery — LOCATION (City, town, or county) Hyattsville, (State) Md.

DATE REC'D BY LOCAL REG. 10/5/50 — REGISTRAR'S SIGNATURE J. Wilson Dodd — 24. FUNERAL DIRECTOR J. Arthur Walters, 254 Carroll St NW DC — ADDRESS

Takoma Park, D.C.

34877

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 9 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10416

# CERTIFICATE OF DEATH

Reg. Dist. No. 2-17

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery — MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Olney Md; LENGTH OF STAY (in this place) —; HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Olney Md; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) VIRGINIA (Middle) JACKSON (Last) Ray

4. DATE OF DEATH: (Month) 10 (Day) 18 (Year) 1950

5. SEX: FEMALE

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) WIDOWED

8. DATE OF BIRTH: Oct 5 1862

9. AGE last birthday: 88 yrs. If under 1 year: Months — Days —; If under 24 hrs.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Montgomery Co Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Letson Riggs

14. MOTHER'S MAIDEN NAME: Caroline L. Woodward

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. —

17. INFORMANT AND ADDRESS: Mrs Claude Hoffs Colesville Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Chronic Myocarditis | 2 years |
| 443X 93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Hypertensive Cardiovascular Disease | 20 yrs |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. —

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 19 ..., 19 48, to 10/18, 1950, that I last saw the deceased alive on 10/17, 1950, and that death occurred at 8:25 a.m., from the causes and on the date stated above.

SIGNATURE C. N. Bryan (Degree or title) M.D. ADDRESS Sandy Spring, Md DATE SIGNED 10/18/50

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF 10-20-50 | NAME OF CEMETERY OR CREMATORY Rockville Union | LOCATION (City, town, or county) Montgomery Co (State) Md

DATE REC'D BY LOCAL REG. 10-19-50 | REGISTRAR'S SIGNATURE Gertrude B Fawley

24. FUNERAL DIRECTOR Roy W. Barber Laytonsville ADDRESS Md

52086

RECEIVED
OCT 25 1950
BUREAU V. S

FILM No. G 1 2 NOV 29 1950
re accident. ams

# MARYLAND STATE DEPARTMENT OF HEALTH
# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

10417

Reg. Dist. No. 213

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Montrose-R.F.D.Rockville, — LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Auto accident on Rt. 240

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington Grove
STREET ADDRESS (If rural give location) R.F.D. Gaithersburg, Md.

3. NAME OF DECEASED (Type or Print): (First) CHARLES (Middle) B. (Last) RICKETTS
4. DATE OF DEATH: (Month) October (Day) 21, (Year) 1950

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Single | 7 Nov.1923 | 26 yrs. | 11 | 14 | | |

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Planter- Gardener
10b. KIND OF BUSINESS OR INDUSTRY: Landscaping (...Wide Co.)
11. BIRTHPLACE (State or foreign country): Rockville, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jesse Ricketts
14. MOTHER'S MAIDEN NAME: Helen Mobley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service) W.W. II
16. SOCIAL SECURITY NO.: 218-16-0766
17. INFORMANT: Jesse Ricketts

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Cerebral hemorrhage due to | sudden |
| 8235 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. 170C | (b) fracture of skull | death |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY highway — (CITY OR TOWN) Montrose — (COUNTY) Mont — (STATE) md
TIME OF INJURY (Month) (Day) (Year) (Hour): 10-21-50-3.15a m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Auto accident - car left highway and ran into tree. (11-29-50 ams)

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: Frank J. Bouchart — (Degree or title) M.D. — ADDRESS: Gaithersburg md — DATE SIGNED: 10-21-50

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 24 Oct.1950 | Arlington National | Arlington, Virginia |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 10/24/50 | Peggy N. Veazey | Robert A. Pumphrey | Bethesda, Md. |

VS. A15A

RECEIVED
OCT 25 1950
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10418

# CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BETHESDA; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS SUBURBAN HOSPITAL 8600 OLD GEORGETOWN ROAD

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda; STREET ADDRESS (If rural, give location) 306 Wilson Lane

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| George | Martin | Roberts | Oct. | 3 | 1950 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | M | Nov. 1 1873 | 76 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Owner | Printing Bus. | Hines Co Miss. | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| E M Roberts | Marie A Brady |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| | | George B Roberts Son |

18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Chronic Myocarditis | |
| 422.2 Antecedent cause(s) | | |
| 932 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) with pulmonary edema | |
| | (c) massive bilateral | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐ |
|---|---|---|
| | | |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from Sept. 28, 1950, to Oct. 3, 1950, that I last saw the deceased alive on Oct 3, 1950, and that death occurred at 3:35 p.m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Alfred L. Norton | M.D. | 546 Maple Ridge Road Bethesda Md. | 10/4/50 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 6 Oct 1950 | Rock Creek Cemetery | Washington, D.C. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| 10-4-50 | Helen Kurrack | Robert A. Pumphrey, Bethesda, Md. |

156M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 9 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

10419

Reg. Dist. No. 215

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda, Rural
LENGTH OF STAY (in this place) 2 mo 8 da
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE District of Columbia COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural, give location) 1900 Second Street, N.E.

3. NAME OF DECEASED (Type or Print) (First) George (Middle) Carrol (Last) ROBINSON
4. DATE OF DEATH (Month) October (Day) 4, (Year) 1950

5. SEX Male
6. COLOR OR RACE Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH June 5, 1890
9. AGE last birthday 60 yrs. If under 1 year Months 04 Days 00 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY Various
11. BIRTHPLACE (State or foreign country) South Carolina
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Robert ROBINSON
14. MOTHER'S MAIDEN NAME Annie WILLIAMS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW I
16. SOCIAL SECURITY NO. - - - - - - -
17. INFORMANT AND ADDRESS Wife: Edith ROBINSON

18. MEDICAL CERTIFICATION Same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Pulmonary Embolism | 6 hrs. |
| 157X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Carcinoma, head of Pancreas | 6 mos. |
| 46g | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 27, 1950, to Oct. 4, 1950, that I last saw the deceased alive on Oct. 4, 1950, and that death occurred at 5:05 P.m., from the causes and on the date stated above.

SIGNATURE J. R. Shanahan (Degree or title) ADDRESS DATE SIGNED
J. R. SHANAHAN, LTJG, MC, USN U.S. NAVAL HOSPITAL October 5, 1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Oct. 9, 1950
NAME OF CEMETERY OR CREMATORY Arlington National
LOCATION (City, town, or county) (State) Arlington, Virginia

DATE REC'D BY LOCAL REG. Oct. 5, 1950
REGISTRAR'S SIGNATURE Edith Whittington
24. FUNERAL DIRECTOR ADDRESS W. E. Jarvis, 1432 U Street, NW, Washington, D.C. W. E. Jarvis Co (W.C.C.)

98844

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10420

# CERTIFICATE OF DEATH

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda, Rural; LENGTH OF STAY (in this place) 5 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE District of Columbia; COUNTY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington; STREET ADDRESS (If rural, give location) 1738 Q Street, N.W.

3. NAME OF DECEASED (Type or Print): (First) Idaline (Middle) Murphy (Last) ROBNETT

4. DATE OF DEATH: (Month) (Day) (Year) October 15, 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Nov 7, 1876

9. AGE last birthday: 73 yrs. If under 1 year: Months 11 Days 09; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: - - - -

11. BIRTHPLACE (State or foreign country): Texas

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: John MURPHY

14. MOTHER'S MAIDEN NAME: Mary A. VERNON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) - - - -

16. SOCIAL SECURITY NO. - - - - - - -

17. INFORMANT AND ADDRESS: Son: Vernon P. ROBNETT

18. MEDICAL CERTIFICATION: Same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Myocardial failure | 10 days |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Hypertensive Cardiovascular Disease | 1 day or less |
| | (c) | |

443X
93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes X No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 11, 1950, to Oct 15, 1950, that I last saw the deceased alive on Oct 15, 1950, and that death occurred at 10:25 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

J. W. FLYNN, LTJG, MC, USN U.S. NAVAL HOSPITAL October 16, 1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: Oct 18, 1950 | NAME OF CEMETERY OR CREMATORY: Arlington National | LOCATION (City, town, or county) (State): Arlington, Virginia

DATE REC'D BY LOCAL REG.: Oct. 16, 1950 | REGISTRAR'S SIGNATURE: Edith Worthington

24. FUNERAL DIRECTOR ADDRESS: S. H. HINES, 2901 14th Street, NW, Washington, D.C.

RECEIVED
OCT 18 1950
BUREAU V. S

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10421

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

**1. PLACE OF DEATH:**

County: Montgomery

City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Mos.

Hospital, institution, or street address where death occurred: 5612 Wisconsin Ave

How long in hospital or institution? 2 Mos

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6424 Barnaby St. N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

**3.(a) FULL NAME:** ESTELLE DOVIE SERRANO

**3.(b) Social Security Number:** —

4. Sex: Femal

5. Color or race: white

6.(a) Single, married, widowed, or divorced: widowed

6.(b) Name of husband or wife: Michael Serrano

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Jan 29 1876

8. AGE: Years 74 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace: Thurmond Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Albert Foreman
13. Birthplace: Maryland

MOTHER
14. Maiden name: Katherine Pennel
15. Birthplace: Md.

16. Informant: Mrs. Evelyn K. Risegari

Address: 6424 Barnaby St. N.W.

17. Burial (Burial, cremation, or removal, Which?) Date thereof: 10-12-50 (month) (day) (year)

Cemetery or crematory: Glenwood Cemetery

Location: Washington, D.C.

16. Funeral director: S. H. Hines Co.

Address: Washington, D.C.

19. 10-16-50 19 (Date rec'd by registrar) Helen Kurnack Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: 10 October 1950, at 2:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 August 1950, to 10 October 1950 and that I last saw her alive on 9 October 1950

Immediate cause of death: congestive heart failure — DURATION: 12 days

Due to: myocarditis, chronic — ?

II also Pneumonia, lobar — 5 days

Other conditions: Generalized arteriosclerosis and chronic osteoarthritis
(Include pregnancy within 3 months of death)

Major findings of operations: 422.2 / 108 Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: Herbert Martyn Jr. M.D. (M. D. or other)

Address: 5029 Bethesda Ave Beth Date signed: 10 Oct 50

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 13 1959
BUREAU P. S.

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10422

# CERTIFICATE OF DEATH

Reg. Dist. No. 213

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY MONTGOMERY MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE New York COUNTY City |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rockville — LENGTH OF STAY (in this place) 14 days | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN New York |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Hilltop San. | STREET ADDRESS (If rural, give location) 399 Park Ave. ✓ |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) | (First) MARSHALL | (Middle) PERRY | (Last) SLADE | 4. DATE OF DEATH | (Month) Oct. | (Day) 31 | (Year) 1950 |
| 5. SEX MALE | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED | 8. DATE OF BIRTH Nov. 4, 1861 | 9. AGE last birthday 88 yrs. | If under 1 year Months. | Days | If under 24 hrs. Hours Min. |

| | | | |
|---|---|---|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Factory Owner | 10b. KIND OF BUSINESS OR INDUSTRY Clothing | 11. BIRTHPLACE (State or foreign country) Pennsylvania | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Jarvis Slade | | 14. MOTHER'S MAIDEN NAME Hanna Patton | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Mrs Bertha C. Slade (wife) | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.0 Immediate cause (a) Arteriosclerotic Heart Disease — many years

Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senility, hypertension, infection of leg.

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑ |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE) |
| TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from 10/17, 1950, to 10/31, 1950, that I last saw the deceased alive on 10/30, 1950, and that death occurred at 8:30 A.m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Travis Kasle M.D. | | Chestnut Lodge Rockville Md. | 10/31/50 |

| | | | |
|---|---|---|---|
| 23. BURIAL, CREMATION REMOVAL (Specify) Cremation | DATE 1 Nov. 1950 | NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory | LOCATION (City, town, or county) (State) Suitland, Maryland |
| DATE REC'D BY LOCAL REG. 11.2.50 | REGISTRAR'S SIGNATURE Peggy U. Veazey | 24. FUNERAL DIRECTOR Robert A. Pumphrey | ADDRESS Bethesda, Md. |

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NOV 6 1950
BUREAU OF S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10423

# CERTIFICATE OF DEATH

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park
LENGTH OF STAY (in this place) 3 mos
HOSPITAL OR INSTITUTION OR STREET ADDRESS 716 Hudson Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Washington, D.C. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural, give location) 1213 Emerson St., N.W. ✓

3. NAME OF DECEASED (Type or Print): (First) Albert (Middle) (Last) Smith

4. DATE OF DEATH: (Month) Oct. (Day) 27 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: June 30 1860

9. AGE last birthday: 90 yrs. If under 1 year: Months 3 Days 27 If under 24 hrs.: Hours Mln.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Methodist Clergy

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Mass.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Eleazar Smith

14. MOTHER'S MAIDEN NAME: Laura R. Grout

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No

16. SOCIAL SECURITY No. None

17. INFORMANT AND ADDRESS

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Thrombosis — Stated 3 months ago.

420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis, generalized

51b (c) Senility

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma of Prostate — Stated 3 Feb 1950 (Deceased)

19a. DATE OF OPERATION: 17 April 1950

19b. MAJOR FINDINGS OF OPERATION: Adenocarcinoma of Prostate

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb, 1950, to 26 Oct, 1950, that I last saw the deceased alive on 26 October 1950, and that death occurred at 8:30 A m., from the causes and on the date stated above.

SIGNATURE: Edward E. Ferguson (Degree or title) M.D. ADDRESS 1801 Eye St N.W., Wash 6, D.C. DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify): Burial Transit — DATE THEREOF 27Oct1950 — NAME OF CEMETERY OR CREMATORY: Wilkinson Funeral Home — LOCATION (City, town, or county) (State): Belknap County N.H.

DATE REC'D BY LOCAL REG. 10-28-50 — REGISTRAR'S SIGNATURE Helen Kurvach

24. FUNERAL DIRECTOR: Robert A. Pumphrey — ADDRESS: Bethesda, Md

V 0844

RECEIVED
OCT 31 1950
BUREAU V. S.

10424

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda, Rural
LENGTH OF STAY (in this place) 7 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE District of Columbia; COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural, give location) 50 New York Avenue, NE ✓

3. NAME OF DECEASED (Type or Print): (First) Candace (none); (Middle) Du Vall (none); (Last) SNYDER

4. DATE OF DEATH: (Month) October (Day) 30, (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Oct 24, 1950

9. AGE last birthday: 00 yrs. If under 1 year: Months 00, Days 07; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): - - - - - - - -

10b. KIND OF BUSINESS OR INDUSTRY: - - - - - -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Charles W. SNYDER

14. MOTHER'S MAIDEN NAME: Helen Marie EASTER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) - - - -

16. SOCIAL SECURITY NO. - - - - - - -

17. INFORMANT AND ADDRESS: Mother: Helen Marie SNYDER

18. MEDICAL CERTIFICATION: Same as item # 2

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

760.5 **Immediate cause** (a) Hemorrhage Intracranial — Interval between onset and death: 6 days

160a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Prematurity

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 24, 1950, to Oct 30, 1950, that I last saw the deceased alive on Oct 30, 1950, and that death occurred at 2:55 A m., from the causes and on the date stated above.

SIGNATURE A. Gedarovich (Degree or title) — ADDRESS U.S. NAVAL HOSPITAL — DATE SIGNED October 30, 1950

A. GEDAROVICH, LTJG, MC, USN

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF Nov. 2, 1950 | NAME OF CEMETERY OR CREMATORY Arlington National | LOCATION (City, town, or county) Arlington, Virginia (State)

DATE REC'D BY LOCAL REGISTRAR Oct 30, 1950 | REGISTRAR'S SIGNATURE Edith Whittington

24. FUNERAL DIRECTOR: Hysong, 1300 N Street, NW, Wash. DC — ADDRESS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

S. A15

RECEIVED
NOV 2 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10425

# CERTIFICATE OF DEATH

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Chevy Chase; LENGTH OF STAY (in this place) 20 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS 20 Oxford St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Montgomery; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Chevy Chase; STREET ADDRESS (If rural, give location) 20 Oxford St.

3. NAME OF DECEASED (Type or Print): (First) Jessie (Middle) Bailey (Last) Stewart

4. DATE OF DEATH: (Month) 10 (Day) 4 (Year) 1950

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: 12-10-1863

9. AGE last birthday: 86 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Rhinebeck N.Y.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Benjamin F. Bailey

14. MOTHER'S MAIDEN NAME: Ella J. Stewart

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: —

17. INFORMANT AND ADDRESS: Elizabeth L. Stewart, Niece

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

421.4 **Immediate cause** (a) Congestive heart failure — Interval Between Onset and Death: 2 weeks

**Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

422 (b) Chronic valvular heart disease — ? years

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY:

(CITY OR TOWN):

(COUNTY):

(STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 11, 1946, to Oct 4, 1950, that I last saw the deceased alive on Oct 3, 1950, and that death occurred at 930 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title): John Egan MD ADDRESS: 6001 Nevada Ave NW Wash 15, DC DATE SIGNED: Oct 4-1950

23. BURIAL, CREMATION, REMOVAL (Specify): Cremation

DATE THEREOF: 10-5-50

NAME OF CEMETERY OR CREMATORY: Ft. Lincoln

LOCATION (City, town, or county) (State): Prince Georges Co. Md.

DATE REC'D BY LOCAL REG.: 10-4-50

REGISTRAR'S SIGNATURE: Helen Kurvach

24. FUNERAL DIRECTOR: S. H. Hines Co. ADDRESS: Washington, D.C.

RECEIVED
OCT 9 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10426

# CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | |
|---|---|
| 1. PLACE OF DEATH · COUNTY: Montgomery MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Virginia COUNTY: |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: American Univ. Park — LENGTH OF STAY (in this place): 1 day | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Colonial Beach |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS: Son's Home | STREET ADDRESS (If rural, give location): ✓ |

| | | | | | |
|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) | (First) LeRoy | (Middle) [redacted] | (Last) Stowe | 4. DATE OF DEATH (Month) Oct. (Day) 24, | (Year) 1950 |
| 5. SEX: Male | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married | 8. DATE OF BIRTH: 26June1878 | 9. AGE last birthday: 72 yrs. | If under 1 year: Months 3, Days 8; If under 24 hrs.: Hours, Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Physician | 10b. KIND OF BUSINESS OR INDUSTRY: Med. Profession | 11. BIRTHPLACE (State or foreign country): Sherman, Texas | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME: Charles L. Stowe | 14. MOTHER'S MAIDEN NAME: Maude Fitch | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If year, give war or dates of service) Spanish American | 16. SOCIAL SECURITY NO.: None | 17. INFORMANT: LeRoy F. Stowe (son) | | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1 Immediate cause (a) Myocardial Infarction — ? days

Antecedent cause(s)

94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐ |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE) | |
| TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from Oct. 23, 1950 to Oct. 24, 1950, that I last saw the deceased alive on Oct. 24, 1950, and that death occurred at 4:30 A.m., from the causes and on the date stated above.

SIGNATURE: Karl Dortzback (Degree or title) — ADDRESS: 3130 Wis. Ave. N.W. Wash., D.C. — DATE SIGNED: 10/24/50

| | | | |
|---|---|---|---|
| 23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE: 27 Oct. 1950 | NAME OF CEMETERY OR CREMATORY: Arlington National | LOCATION (City, town, or county) (State): Arlington, Virginia |
| DATE REC'D BY LOCAL REG.: 10-25-50 | REGISTRAR'S SIGNATURE: Helen Kurvack | 24. FUNERAL DIRECTOR: Robert A. Humphrey | ADDRESS: Bethesda, Md. |

8

V3292

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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OCT 27 1980
BERKELEY, CA

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10427

# CERTIFICATE OF DEATH

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH — COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 8100 Old Georgetown Rd. Suburban Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: D. C. — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Washington
STREET ADDRESS (If rural, give location): 4104 Jennifer St. N.W.

3. NAME OF DECEASED (Type or Print): (First) Earl (Middle) D. (Last) Taylor

4. DATE OF DEATH: (Month) 10 (Day) 26 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: June 7 1892

9. AGE last birthday: 58 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Traffic Manager

10b. KIND OF BUSINESS OR INDUSTRY: Gen. Accounting Office

11. BIRTHPLACE (State or foreign country): Stuart Iowa

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George W Taylor

14. MOTHER'S MAIDEN NAME: Jessie Stillwell Heathcington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service): World War I

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Mrs C.V. Parker 18 Bolling Rd RFD #1 Alexandria Va

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Hemiplegia, left, severe — Interval between onset and death: Two days

Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

334X (b) Essential Hypertension — 5 yrs +

83d (c) Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-24-, 1950, to 10-26-, 1950, that I last saw the deceased alive on 10-26-, 1950, and that death occurred at 1:07 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Stewart Schaaff M.D. ADDRESS: 3921 Ingomar St. N.W. DATE SIGNED: 10-27-50

23. BURIAL, CREMATION, REMOVAL (Specify): Removal — DATE: 27 Oct. 1950 — NAME OF CEMETERY OR CREMATORY: Alexandria, Va. — LOCATION (City, town, or county) (State): Alexandria, Va.

DATE REC'D BY LOCAL REG.: 10-27-50 — REGISTRAR'S SIGNATURE: Helen Kurvach — 24. FUNERAL DIRECTOR: Demaine Fun. Home — ADDRESS: 520 Mt. Vernon Blvd Alexandria, Va. 6048

RECEIVED
OCT 31 1950
BUREAU V. S

10428

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 214

| | |
|---|---|
| 1. PLACE OF DEATH · COUNTY Montgomery MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED · STATE WASH. DC COUNTY |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spgs. LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS 10000 Georgia Ave. | STREET ADDRESS (If rural give location) 4811 Blagden Ave N.W. |

| | | | | | |
|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) (First) Arvilla (Middle) V. (Last) THOMA | | | 4. DATE OF DEATH (Month) 10 (Day) 25 (Year) 1950 | | |
| 5. SEX F | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH 2-9-74 | 9. AGE last birthday 76 yrs. | If under 1 year Months 8 Days 16 / If under 24 hrs. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) Columbus Ohio | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME Harvey Parry | | | 14. MOTHER'S MAIDEN NAME Margaret Callahan | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT Jos. Thoma | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

422.1 Immediate cause (a) ACUTE MYOCARDITIS

93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) CHRONIC MYOCARDITIS

(c) GENERALIZED ARTERIOSCLEROSIS

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. SENILITY.

| | | |
|---|---|---|
| 19a. DATE OF OPERATION NONE | 19b. MAJOR FINDINGS OF OPERATION — | 20. AUTOPSY? Yes ☐ No ☑ |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) NONE | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE) | |
| TIME OF INJURY (Month) (Day) (Year) (Hour) NONE m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from Oct 24, 1950, to Oct 25, 1950, that I last saw the deceased alive on Oct 25, 1950, and that death occurred at 7:15 P.m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Henryka Lowden | MD. | 1603 19TH ST N.W. Washington, D.C. | |

| | | | |
|---|---|---|---|
| 23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE THEREOF 10-28-50 | NAME OF CEMETERY OR CREMATORY Cedar Hill Cem. | LOCATION (City, town, or county) (State) Suitland, MD. |
| DATE REC'D BY LOCAL REG. 10-27-50 | REGISTRAR'S SIGNATURE Frances Cotter | 24. FUNERAL DIRECTOR The S. H. Hines Co. | ADDRESS 2901 14th St. N.W. |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 2 1950
BUREAU T. S

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

10429

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH**
COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda, Rural
LENGTH OF STAY (In this place): 5½ hours
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U.S. Naval Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE: Louisiana — COUNTY: Caddo
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Shreveport, Rural
STREET ADDRESS (If rural give location): Box # 698, RFD # 2 ✓

**3. NAME OF DECEASED** (Type or Print): (First) Clyde (Middle) (none) (Last) THOMPSON

**4. DATE OF DEATH**: (Month) October (Day) 6, (Year) 1950

**5. SEX**: Male

**6. COLOR OR RACE**: White

**7. SINGLE, MARRIED, WIDOWED, DIVORCED** (Specify): Single

**8. DATE OF BIRTH**: Feb. 1, 1929

**9. AGE** last birthday: 21 yrs. — If under 1 year: Months 08 / Days 06 — If under 24 hrs.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): U.S. Marine

**10b. KIND OF BUSINESS OR INDUSTRY**: Armed Forces

**11. BIRTHPLACE** (State or foreign country): Arkansas

**12. CITIZEN OF WHAT COUNTRY?**: US

**13. FATHER'S NAME**: Burnie H. THOMPSON

**14. MOTHER'S MAIDEN NAME**: Rose ARMSTRONG

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): YES (If yes, give war or dates of service): - - -

**16. SOCIAL SECURITY NO.**: - - - - - - -

**17. INFORMANT**: U.S. Marine Corps records

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| **Immediate cause** | (a) Hemorrhage due to bullet wound | |
| **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Thru Skull (suicide) | 5 hrs |
| | (c) | |

976X
164C

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION** | **19b. MAJOR FINDINGS OF OPERATION** | **20. AUTOPSY?** Yes ☒ No ☐

**21. EXTERNAL CAUSE WAS** PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: U.S.N. Com. Sta. — (CITY OR TOWN): Washington — (COUNTY) — (STATE): D.C.

TIME OF INJURY (Month) (Day) (Year) (Hour): Oct 5 50 8 p.m. — INJURY OCCURRED While at work ☐ Not while at work ☒ — HOW DID INJURY OCCUR?: self inflicted gun shot wound

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

SIGNATURE: Frank J. Broschart — (Degree or title) — ADDRESS — DATE SIGNED

Frank J. BROSCHART, M.D. — GAITHERSBURG, MARYLAND — October 6, 1950

**23. BURIAL, CREMATION, REMOVAL** (Specify): Removal — DATE THEREOF: Oct. 6, 1950 — NAME OF CEMETERY OR CREMATORY — LOCATION (City, town, or county) (State): Shreveport, Louisiana

DATE REC'D BY LOCAL REG.: Oct. 6, 1950 — REGISTRAR'S SIGNATURE: Elsie Washington

**24. FUNERAL DIRECTOR** — ADDRESS: Wastler Funeral Home, 301 East Capitol St., Washington, D.C.

60996 D. C. 5

VS. A15A

RECEIVED
OCT 9 1950
BUREAU Y. S.

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# MARYLAND STATE DEPARTMENT OF HEALTH

10430

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH
COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Silver Spring
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 1612 South Springwood Drive

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Pennsylvania — COUNTY: Lackawanna
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Scranton
STREET ADDRESS (If rural, give location): Webster 533 South Weston Avenue ✓

3. NAME OF DECEASED (Type or Print): (First) Walter (Middle) (Last) Thompson

4. DATE OF DEATH: (Month) Oct. (Day) 4 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Oct. 12, 1876

9. AGE last birthday: 73 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bldg. Superintendent

10b. KIND OF BUSINESS OR INDUSTRY: Scranton Lace Co.

11. BIRTHPLACE (State or foreign country): Scranton, Pennsylvania

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Thompson

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY No.:

17. INFORMANT AND ADDRESS: Mr. William Reid, 1612 So. Springwood Drive Silver Spring, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Carcinoma of Esophagus | 2 years |
| 150x 46a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Generalized metastases | 8 Months |
| | (c) Cachexia and malnutrition | 5 weeks |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Roentgen-Ray Therapy — 10months

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION: **

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): No

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): X (CITY OR TOWN): XXXXXXXX (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): XXXXXXXXXX m.

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR? XXXXXXXXXX

22. I hereby certify that I attended the deceased from 9-23, 1950, to 10-4, 1950, that I last saw the deceased alive on 10-4, 1950, and that death occurred at 4 A. m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| M. E. Shoemaker M.D. | | 8005 Woodbury Drive Silver Spring, Md. | 10/4/50 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial & Removal | 10/7/50 | Abington Hills Cemetery | ClarksSummit, Pa. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 10/5/50 | Frances Potter | Warner E. Pumphrey | 8131 Ga. Ave. Silver Spring, Maryland |

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
OCT 10 1950
BUREAU V. S

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10431

# CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park
LENGTH OF STAY (in this place) 22 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Sanitarium

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
STREET ADDRESS (If rural, give location) 1106 Wayne ave

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Rosina Mary Elizabeth Thorn

4. DATE OF DEATH (Month) (Day) (Year) 10 28 1950

5. SEX female
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed
8. DATE OF BIRTH 1-31-74
9. AGE last birthday 76 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Wash. D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Conrad Schwab
14. MOTHER'S MAIDEN NAME Katherine Jacob

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Intestional Obst. — INTERVAL BETWEEN ONSET AND DEATH 4

153x

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Annular Carcinoma at Splenic flexure?

46 e

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Bronchopneumonia left lower Infarction lower Lung

19a. DATE OF OPERATION 10/28/50
19b. MAJOR FINDINGS OF OPERATION distorted ascending + transverse colon - Cannular tumor
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/6, 1950, to 10/28, 1950, that I last saw the deceased alive on 10/28, 1950, and that death occurred at 7 55 p m., from the causes and on the date stated above.

SIGNATURE Howard T Morse (Degree or title) MD ADDRESS 28 Carroll Ave Takoma Park Md DATE SIGNED 10/28/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 11/1/50
NAME OF CEMETERY OR CREMATORY Arlington National Cemetery
LOCATION (City, town, or county) Arlington County (State) Va.

DATE REC'D BY LOCAL REG. Oct 30-50
REGISTRAR'S SIGNATURE J. Wilson Dodd
24. FUNERAL DIRECTOR Warner E Pumphrey, Inc. ADDRESS Silver Spring Md

52086

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BUREAU V. S

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10432

# CERTIFICATE OF DEATH

Reg. Dist. No. 214

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Silver Spring
LENGTH OF STAY (in this place): 9/3/50
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 10,621 S. Dunmoor Drive

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Silver Spring
STREET ADDRESS (If rural, give location): 9504 Columbia Boulevard

3. NAME OF DECEASED (Type or Print): (First) MARION (Middle) KEATING (Last) WAHLFORS

4. DATE OF DEATH: (Month) Oct. (Day) 15, (Year) 1950

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: March 5,1880

9. AGE last birthday: 70 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretarial work

10b. KIND OF BUSINESS OR INDUSTRY: Furniture

11. BIRTHPLACE (State or foreign country): Petersville, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Marshall Keating

14. MOTHER'S MAIDEN NAME: Temple Anna Winter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

16. SOCIAL SECURITY No.: 577-09-0977

17. INFORMANT AND ADDRESS: 9504 Columbia Blvd., Gustave W. Wahlfors, Silver Spring, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

172X — Immediate cause (a) acute congestive failure — Interval between onset and death: 10 min.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last — 488 — (b) Cancer of Left Ovary and Adrenal Abdominal Metastases — 8 mo.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Prior, 19 48, to 10-15, 19 50 that I last saw the deceased alive on 10-13, 1950, and that death occurred at 8:1 m., from the causes and on the date stated above.

SIGNATURE: Joseph Rogers M.D. (Degree or title) — ADDRESS: 1082 Lamberg Rd. Silver Spring Md. — DATE SIGNED: 10-15-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Oct.18,1950 — NAME OF CEMETERY OR CREMATORY: St.Mark'sEpiscopal Church Cem. — LOCATION (City, town, or county) (State): Petersville, Maryland

DATE REC'D BY LOCAL REG.: 10/15/50 — REGISTRAR'S SIGNATURE: Frances Potter

24. FUNERAL DIRECTOR: Warner E. Pumphrey — ADDRESS: Silver Spring, Md.

23667

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OCT 20 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

10433

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH: COUNTY Montgomery; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Olney
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS The Montgomery County General Hospital Inc.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cedar Grove
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Harry (Middle) L (Last) Watkins
4. DATE OF DEATH: (Month) October (Day) 30 (Year) 1950

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 4/25/1872
9. AGE last birthday: 78 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Own Farm
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lorenzo D. Watkins
14. MOTHER'S MAIDEN NAME: Jane Purdum

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause (a) Coronary Thrombosis with Myocardial Infarction — Interval Between Onset and Death: 5 days.

94 a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Coronary Artery Heart Disease

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 25, 1950, to Oct. 30, 1950, that I last saw the deceased alive on Oct. 29, 1950, and that death occurred at 7 00 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Jack Schumacher M. D. ADDRESS Barnesville, Md. DATE SIGNED Oct. 30, 1950

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: Nov 1 1950
NAME OF CEMETERY OR CREMATORY: Upper Seneca Baptist
LOCATION (City, town, or county) (State): Cedar Grove Md
DATE REC'D BY LOCAL REG. 10-31-50
REGISTRAR'S SIGNATURE: Gertrude B Fowler
24. FUNERAL DIRECTOR: Olin L. Molesworth ADDRESS Damascus Md.

APPROVED

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 212

10434

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rockville, RFD 17 yrs
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Virginia COUNTY Wyth
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Wytheville
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Annie (Middle) Harrison (Last) Whisman

4. DATE OF DEATH (Month) Oct (Day) 25 (Year) 1950

5. SEX F

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Oct 5 1909

9. AGE last birthday 41 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT Frank Whisman

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Generalized Metastatic Carcinoma — Interval between onset and death: 5 month

170X

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Carcinoma of Breast — about 3 years

50

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1949, to 25 Oct, 1950, that I last saw the deceased alive on 25 Oct, 1950, and that death occurred at 11:40 A m., from the causes and on the date stated above.

SIGNATURE Gordon McSmith (Degree or title) M.D. ADDRESS Barnesville, Md DATE SIGNED 26 Oct 50

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF 10/28/50

NAME OF CEMETERY OR CREMATORY Monocacy

LOCATION (City, town, or county) (State) Beallsville Md.

DATE REC'D BY LOCAL REG. Oct 27, 1950

REGISTRAR'S SIGNATURE Charles A. Griffin

24. FUNERAL DIRECTOR William B. Hilton ADDRESS Barnesville, Md

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BUREAU V. S

10435

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 223

1. PLACE OF DEATH: COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Takoma Park
LENGTH OF STAY (in this place) [illegible]
HOSPITAL OR INSTITUTION OR STREET ADDRESS Wash. San. & Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
STREET ADDRESS (If rural give location) 2505 Forest Glen Road

3. NAME OF DECEASED (Type or Print) (First) John (Middle) (Last) Wise

4. DATE OF DEATH (Month) Oct. (Day) 25 (Year) 1950

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single

8. DATE OF BIRTH 5/13/41

9. AGE last birthday 9 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Schoolboy

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Takoma Park, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Joel C. Wise

14. MOTHER'S MAIDEN NAME Anna L. Shauck

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mr. Joel C. Wise - 2505 Forest Glen Rd. Silver Spring, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Cerebral hemorrhage due to | 20 min. |
| 813.5 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) fracture of skull | |
| 1700 | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) highway
(CITY OR TOWN) Silver Spring (COUNTY) Monty (STATE) md
TIME OF INJURY (Month) Oct (Day) 25 (Year) 50 (Hour) 1230 p m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? struck by auto while riding bicycle

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE Frank J. Broschart (Degree or title) M.D. ADDRESS Gaithersburg Md DATE SIGNED 10-25-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 10/28/50
NAME OF CEMETERY OR CREMATORY St. John's Cemetery
LOCATION (City, town, or county) Montgomery County (State) Md.

DATE REC'D BY LOCAL REG. Oct 27, 1950
REGISTRAR'S SIGNATURE J. W. Dudley Dpty Reg
24. FUNERAL DIRECTOR Warner E. Pumphrey, ADDRESS 8434 Ga. Ave., Silver Spring, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

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OCT 30 1950
BUREAU V. S

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10436

Reg. Dist. No. 214

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

**1. PLACE OF DEATH:**
County: Montgomery
City or town: Crest Haven
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 58 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Crest Haven Drive
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3.(a) FULL NAME:** Isabel Withers

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F | Colored | Married |

6.(b) Name of husband ~~or wife~~: Archie Withers
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 1, 1879

**8. AGE:** Years: 71 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Home
11. Industry or business

FATHER
12. Name: John Berry
13. Birthplace: Va

MOTHER
14. Maiden name: Sarah Mallory
15. Birthplace: Va

16. Informant: Alberta Withers
Address: Crest Haven Drive

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 10 7 1950 (month) (day) (year)
Cemetery or crematory: Sligo Cemetery
Location: Takoma Park, Md
18. Funeral director: W Ernest Jarvis Co
Address: 1432 You St NW
19. 10/5/50 (Date rec'd by registrar) Frances Potter Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Oct 4 1950 at 9:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1947 to Oct 4 1950 and that I last saw h.er alive on Oct 4 1950

| Immediate cause of death | DURATION |
|---|---|
| Arteriosclerotic Cardio-vascular disease | unknown |
| Due to: Cardiac failure | 2 months. |
| Due to: | |
| Other conditions: 422.1 93d | |

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank G. Zack M. D. or other
Address: 8248 Ga Ave Silver Spring Date signed: 10-9-50

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OCT 10 1950
BUREAU T. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10437

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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VS. A15

1. PLACE OF DEATH
COUNTY: Montgomery — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Silver Spring
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. — COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Silver Spring
STREET ADDRESS (If rural give location): 10105 - Gardiner. Ave.

3. NAME OF DECEASED (Type or Print): (First) MARY (Middle) (Last) WIVEL

4. DATE OF DEATH: (Month) Oct. (Day) 18 (Year) 1950

5. SEX: F.

6. COLOR OR RACE: White.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: May 26 1879

9. AGE last birthday: 71 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework.

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Maryland.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John J. Jones.

14. MOTHER'S MAIDEN NAME: Sarah Hamilton.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: William J. Wivel

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Acute Congestive Heart Failure | 6 Hrs |
| 442X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 131a | (b) Cardio-Vascular Renal Disease | 5 Yrs |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: -

19b. MAJOR FINDINGS OF OPERATION: -

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1944, 19..., to Oct. 16, 1950, that I last saw the deceased alive on Oct 17, 1950, and that death occurred at 11:30 P. m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Harold Thayer. MD | | 1835 Eye St NW. Washington DC | 10/19/50 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 21-1950 | New Cathedral Cemetery | Baltimore. Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 10/20/50 | Frances Potter | J.J. Costello. Wash. D.C. | |

10438

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY Mont MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Chevy Chase
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 210 Spring St

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Mont.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Chevy Chase.
STREET ADDRESS (If rural, give location) 210 Spring St.

3. NAME OF DECEASED (Type or Print) (First) JANE (Middle) H. (Last) ~~WILEY~~ WYLIE
4. DATE OF DEATH (Month) Oct (Day) 21 (Year) 1950

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH March 9, 1880
9. AGE last birthday 70 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Leavenworth, Kansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Samuel Himrod
14. MOTHER'S MAIDEN NAME Marion Ball.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS Emily A Himrod 210 Spring St Ch. Ch.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary thrombosis

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

420.1

94a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 1940, to 10-21, 1950, that I last saw the deceased alive on June, 1950, and that death occurred at 1:45 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Wyllo Bert Baker ADDRESS 1635 Harvard St. Wash DC DATE SIGNED 10-21-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Oct. 24, 1950
NAME OF CEMETERY OR CREMATORY Ft. Lincoln
LOCATION (City, town, or county) (State) Brim Gen co. Md.

DATE REC'D BY LOCAL REG. 10-21-50
REGISTRAR'S SIGNATURE Helen Kurvacka
24. FUNERAL DIRECTOR The S H Hines Co. ADDRESS 2901-14th St N.W. Wash D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

RECEIVED
OCT 24 1950
BUREAU V. S.